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**Pathways to episodes of deliberate self-harm among
mentally ill men in a high-secure hospital:
An exploratory study with conceptual development.**

Submitted to the Journal of Forensic Psychiatry and Psychology

(See Appendix A for Instructions for Authors)

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ABSTRACT

There is a dearth of research exploring pathways to episodes of deliberate self-harm (DSH) as experienced by mentally ill men within high-secure hospital settings. The principal aim of this study was to explore the causal pathway(s) to episodes of self-harm experienced by mentally ill men within a high secure hospital. With a secondary aim of developing a conceptual understanding of the development and function of this phenomenon within this often ignored population. Seven men with a history of repetitive DSH participated in audiotaped semi-structured interviews in which they recalled antecedents and functions of typical episodes. Transcribed interviews were analysed and coded using grounded theory methods. Two pathways to episodes of DSH emerged and were subsequently termed, the Relief and the Response to Mental Health Problems Pathways. The Relief Pathway consisted of two inter-related functions; relief and an expression of self-hatred. Within the Response to Mental Health Problems Pathway, episodes of DSH were directly influenced by auditory hallucinations and delusional beliefs. Participation within a dyadic suicide pact emerged as a wholly unexpected theme. Further research is required to substantiate the two-pathway aetiology to episodes of DSH proposed within this study.

Key words: Men, Self-Harm, Suicide, Schizophrenia, High-Secure Hospital, Grounded Theory.

BACKGROUND:

Deliberate self-harm (DSH) describes behaviours in which individuals engage in “self-poisoning or self-injury, irrespective of the apparent purpose of the act” (NICE, 2004, p.7). The present study adopts this definition employing the term DSH to refer to behaviours previously described within the literature as attempted suicide, parasuicide, self-poisoning, self-wounding, self-injury and self-mutilation.

DSH varies significantly between individuals in terms of method, development, function and meaning. Within this study the term ‘function’ is used to describe the purpose served by DSH and the term ‘pathway’ to describe antecedents leading to episodes of DSH. Differing causal pathways to DSH may suggest different intervention needs. Huband and Tantam (2004) identified two pathways to self-wounding among 10 female psychiatric inpatients which they termed the ‘spring’ and ‘switch’ pathways. A recent review suggested that DSH may function in one or more of the seven following ways; affect-regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal-influence, self-punishment and sensation-seeking (Klonsky, 2007). Research exploring risk factors and functions of self-harm have generally employed a checklist method approach (NICE, 2004), in which individuals endorse items they deem to be relevant to their experience of DSH. Although this is a useful approach in bringing order, simplicity and the ability to quantify a complex phenomenon, it may be limited in extending our knowledge of repeated DSH as individuals may self-harm on different occasions for different reasons (Horrocks et al., 2003) and may experience factors and functions related to their DSH which are not identified by checklists. Therefore, research exploring patient experience through a series of open-ended

questions, may offer valuable insights into the antecedents and functions of DSH (NICE, 2004; Klonsky, 2007).

It has been argued that much of our current knowledge with respect to the pathways and functions of DSH is skewed towards white women with a diagnosis of borderline personality disorder (Shaw, 2002). A number of studies have narrowly focused on DSH within this patient population (Dubo et al., 1997; Brown et al, 2002; Shearer, 1997). However, contrary to the impression given by the literature, male DSH constitutes a significant problem which appears to be on the increase. Hawton et al. (1997) reported a 62.1% increase in male DSH in Oxford between 1985-1995. There is comparatively little literature examining male self-harm as an issue deserving of research in its own right and Taylor (2003) argued that male DSH is even less acknowledged, accepted and understood than it is in women. A survey of 8,450 individuals aged between 16-74 across, England, Wales and Scotland, found that approximately half of those diagnosed with schizophrenia had self-harmed at some point during their lives (Meltzer et al, 2002). Forty percent reported experiencing suicidal thoughts (Meltzer, 1998) and more than half had more than one lifetime episode of DSH (Harkavy-Friedman et al, 2001). Bearing in mind that men are more likely than women to successfully complete suicide (Hawton, 2000) and individuals with schizophrenia (Kleespies and Dettmer, 2000) are eight times more likely to commit suicide than those without this diagnosis, it is of critical importance that research exploring the pathways and functions of DSH in men diagnosed with schizophrenia is conducted.

It was estimated that between 1994-1995 the financial cost of DSH within a high secure psychiatric hospital was approximately £227,000, this includes consultant call-

out charges, A and E treatment and escort, inpatient treatment and escort, transport to the hospital and X-rays (Swinton and Smith, 1997). As Low et al. (2001) pointed out this is likely to be a gross underestimate of the true fiscal burden of caring for individuals who repeatedly self-harm within a high secure hospital as it does not account for the cost of close nursing observations such as one-to-one staffing nor the cost of psychological intervention.

There has been relatively little research exploring DSH within patients in high secure hospitals, despite the higher incidence rate of DSH within this patient group compared to the general population (Meltzer, et al., 2002; Low et al., 1997; Jackson, 2000). Studies of DSH within high secure hospitals have generally focused on women (Burrow, 1992; Low et al, 2001; Low et al, 2000; Low et al, 1997) or simply explored the frequency and prevalence of male self-harm (Jackson, 2000; Burrow, 1992). Surprisingly, despite the paucity of research concerned with DSH in high secure populations, gender differences have been found in terms of patient Mental Health Act (1983) classification and frequency of DSH. Studies have found that the frequency of DSH among women within a high secure hospital was significantly greater among those classified with a psychopathic disorder (Burrow, 1992; Low et al., 1997; Swinton et al., 1998). However, Burrow (1992) and Jackson (2000) independently found no difference in the frequency of DSH in male patients classified with a psychopathic disorder and those with a mental illness.

An extensive literature review revealed Jackson (2000) as the only study concerned with DSH within mentally ill men in a high secure hospital. Jackson (2000) used a retrospective research paradigm, exploring nursing case notes over a 30-month period.

Nineteen percent of the 127 patients engaged in DSH during the study period and there were 122 recorded incidents; the most commonly employed method of DSH was cutting. Jackson's (2000) study examined the prevalence and frequency of male DSH within a high-secure hospital, ignoring potential differences in pathways and functions of episodes of DSH. Dedicated research exploring pathways and functions of DSH for this group is essential and is likely to have implications for the care and treatment of mentally ill men who self-harm in other settings.

Aim of Study:

The principal aim of this Grounded Theory study was to explore the causal pathway(s) to episodes of self-harm experienced by a small sample of mentally ill men detained within a high secure hospital, with a secondary aim of developing a conceptual understanding of the development and function of this phenomena within this often ignored population.

The present study addressed two primary research questions:

- (1) What pathways to deliberate self-harm have mentally ill men in a high secure hospital typically experienced?
- (2) What factors differentiate pathways from each other?

(An extended background literature review which expands upon the rationale provided for the study and describes further research questions addressed within this thesis can be found within Appendix B)

METHODOLOGY

A qualitative Grounded Theory (Strauss and Corbin 1994) approach was adopted as the most suited to address the aforementioned aims and research questions. Grounded Theory is a general methodology for theory-development that is grounded in research data which has been systematically gathered and analysed. The data-driven theory develops throughout the research process due to the interplay between data collection and analysis phases. The end result of a Grounded Theory study is the generation of a theory, consisting of a set of plausible relationships proposed among themes and categories identified within the data (*see Appendix C for Extended Methodology*).

The Researcher:

At the time of the study, the researcher was a final year trainee clinical psychologist who practiced predominantly from a cognitive-behavioural perspective which was informed by other theoretical orientations (e.g. object-relations, CAT). The researcher had previous experience of clinical experience of working with both mentally ill men and women who self-harm within a high-secure hospital. Although it could be argued that the researcher's clinical experience with respect to the subject matter and population may reduce objectivity during analysis, Strauss and Corbin (1990, p.46-48) argue that a researcher with prior knowledge or experience of the subject matter of the study has increased 'theoretical sensitivity' which enhances theory-development within a grounded theory study.

Sampling:

The study employed a theoretical sampling technique (Strauss & Corbin, 1990), in which individuals who were likely to provide the greatest insight into the research questions were approached to participate. The theoretical sampling technique employed within the study aimed to maximise the opportunity to discover variations among emerging themes and increase theoretical understanding of categories in terms of their property and dimensions by asking specific questions related to the emerging themes, core categories. Therefore, theoretical sampling aimed to gather data to develop and refine the emerging theory rather than represent a particular population or increase generalisability (Charmaz, 2006 p. 99-101; Strauss & Corbin, 1990 p. 42-46).

Although Strauss and Corbin (1990) suggest that theoretical sampling should continue until the study reaches a theoretical saturation point, the present study was unable to achieve this as only seven participants indicated willingness to participate. Therefore, participants were consecutively recruited to the study until no further willing / eligible participants came forward.

Participants were recruited from the Mental Health Services Directorate (MHSD) within Rampton Hospital, a high secure psychiatric hospital within the UK. The adult patients served by the MHSD are male and are currently detained under the Mental Health Act (MHA, 1983) with a primary legal classification of a Mental Illness.

Participant Inclusion Criteria:

- Male
- Aged 18+

- Currently detained within a high secure psychiatric hospital under the Mental Health Act (1983)
- Legal Classification of Mental Illness and / or Psychopathic Disorder
- Experience of two or more life-time episodes of DSH – as identified by consultant psychiatrist or member of the psychology department

Participant Exclusion Criteria:

- Legal classification of Mental Impairment – as it would have been difficult to ensure informed consent.
- Significant hearing or vision problems that was not rectified by glasses or a hearing aid – as this was thought to compromise obtaining informed consent and the findings of the study.
- Unable to read or speak English or have special communication needs – as this may compromise obtaining informed consent to participate and the use of an interpreter may compromise the validity of the derived data.
- Currently participating within psychological treatment addressing their DSH – as this may compromise therapeutic progress.

Recruitment Process:

The study was approved by Nottingham Research Ethics Committee 2 (*see Appendix D for Ethical Approval Letter*) and Nottinghamshire Healthcare R&D (*see Appendix E for*

R&D Approval Letter.) The following approach was adopted to identify and recruit eligible participants:

The researcher sought permission from consultant psychiatrists to approach patients on their caseload regarding participation in the study. Members of the psychology department and consultant psychiatrists based within the MHSD at Rampton identified and approached potentially eligible participants. These members of staff were given the 'Information Sheet for Staff' (*Appendix F*) in addition to copies of the 'Participant Information Sheet' (*Appendix G*) and the 'Consent Form' (*Appendix H*) which they gave to participants.

Potential participants sent the signed consent form to the researcher via members of their clinical team or the hospital internal mail system. For participants who gave their consent, the researcher contacted their Responsible Medical Officer (RMO) to establish whether participation in the study would have a negative impact upon their mental health and if they fulfilled the eligibility criteria for participation. Those identified as eligible were be contacted by the researcher who described the study in greater detail, discussed the information on the 'Participant Information Sheet' and the 'Consent Form' and answered any questions that participants had regarding their participation. Following this, a mutually agreed date and time was arranged for interviews. Participants had a minimum of one week in which they could decide to take part in the study and did not receive payment for their participation.

Sample Characteristics:

The final sample was comprised of seven participants; this is congruent with qualitative studies of a similar nature (e.g. Jeglic et al, 2005; Huband and Tantam, 2004). Participants were aged between 24 and 44 years ($M = 35.6$ years $SD = 5.9$). Five participants were White-British; one Afro-Caribbean; and one mixed-race Black and White. All seven participants had received a diagnosis of schizophrenia and were detained under MHA (1983) classification of a Mental Illness. Four were held under Section 47/49 and 3 under Section 37/41 of the MHA (1983). All seven participants had committed an index offence of a violent nature; four had committed murder. None of the participants had committed a sexual offence. The length of time since participants last DSH episode ranged from 2 years to 10 years ($M = 6.3$, $SD = 2.91$ years). The number of life-time episodes ranged from 5 to 60 with a median number of life-time episodes of 5. It is important to note that only one participant reported more than 7 lifetime episodes of DSH and therefore their reported 60 lifetime episodes was atypical. Due to the manner in which participants were recruited to the study, the number of participants asked and who refused to participate was unknown.

Data Collection:

Participants took part in a semi-structured interview with the researcher, which lasted between 45 minutes and 2.5 hours approximately. The interview was audio-taped to facilitate transcription and took place in a quiet private room on the ward where the participant resided. The semi-structured interview schedule was designed to collect data regarding typical episodes of DSH; with specific prompts for situations, physiological changes, emotions, and thoughts associated pre and post (*see Appendix I for semi-structured interview schedule*). Participant case files were reviewed for

demographic information following the interview to minimize researcher bias stemming from prior knowledge of participants' history during the interview.

Analysis:

The audio-taped data was transcribed post interview (*see DVD located in front cover of the thesis for all participant transcriptions*). Analysis and coding followed the Grounded Theory and constant comparison methodology proposed by Strauss and Glasser (1967). Initially interview data was compared to other interview data across cases. Through the process of coding and memoing a theory began to evolve that was grounded in the data. Once this theory began to emerge, it was then compared to further data to validate or disconfirm the theory as it stood. The emerging theory had to be able to account for new data.

Coding involved three distinctive phases, Open Coding, Axial Coding and Selective Coding (Strauss & Corbin, 1990):

The Open Coding phase involved the close scrutiny of words, sentences and phrases within the data (*see Appendix J for example of Initial Open Coding based on a single participant. Initial Open Coding for all participants can be found in the DVD*) to identify 'themes' or variables that make sense of what the participant had said. These themes made use of *in vivo codes* drawn directly from the participants' own words. Open Coding allowed analogous themes to be compared and contrasted. Themes of a similar nature were combined (*see Appendix K for example of the themes derived from open coding based on a single participant. All themes derived from the open coding phase can be found in the DVD*).

Within the Axial Coding phase, causal relationships between themes were identified. These relationships were cause, interaction or consequence effects. The aim within this phase was to make explicit connections between themes based upon the data in order to understand the phenomena. At this stage a theory began to emerge and core categories could be identified (*see Appendix L for example of axial coding based on a single participant. All axial coding can be found within the DVD*).

Selective Coding involved identifying themes and core categories which had been endorsed by two or more participants and systematically relating them to other themes and core categories endorsed by these participants. This was achieved by exploring the memos created throughout the analysis. The selective coding phase also involved validating and refining the relationships between themes and core categories. These relationships were then integrated to form a theory regarding pathways specific typical episodes of DSH in this population. This theory was then compared and contrasted with further data to validate or disconfirm the emergent theory.

Memoing occurred throughout the analysis and involved theoretical note making in which the researcher developed hypotheses regarding emergent themes in terms of their properties, dimensions and relationship with other themes in order to form core categories. The researcher also created memos regarding the relationship between themes and core categories. The memoing process, therefore, allowed for theory development and a diagrammatic conceptualisation of the emergent theory (*see Appendix M for an example memo*).

Trustworthiness of Study:

It is particularly important for a qualitative study of this nature to be able to demonstrate the trustworthiness of its findings (Henwood and Pidgeon, 1993). The present study addressed this issue at several levels. The possibility that researcher characteristics may influence the findings was controlled for by ensuring consistency within the interviews; with the same researcher conducting all interviews. The semi-structured interview questions were designed to be free of double negatives or complex jargon and did not contain leading questions nor make assumptions which may lead to biased results. To minimize the possibility of socially desirable responding participants were assured that there were no right or wrong answers and that the study was only concerned with their experiences. Information elicited was reflected back to the participants throughout the interviews, to clarify the validity of the researchers understanding. All interviews were audio-taped to facilitate transcription and an audit trail of the analysis and coding process created. This allowed for repeated examination of the data and opened up the analysis and coding to scrutiny by other researchers. Participants also read through transcripts of their interview and the article write-up and confirmed the accuracy of transcripts and verified that findings reflected their experience. The results section contains a number of quotations from the participants' accounts, thereby providing the readers with an opportunity to form individual opinions regarding the validity of the derived themes, categories and theory.

RESULTS

All seven participants had employed cutting as a means of DSH at some point. All participants had employed multiple methods of DSH over the course of their life; six participants had overdosed, three using prescribed medication; four had attempted hanging; two had jumped, (one under a train and the other off a bridge); one engaged in head-banging; one stabbed himself in the chest; one attempted drowning, one attempted to electrocute himself; one had burnt himself using a lighter; one had gouged out his eye and one had self-circumcised.

The open and axial coding yielded 5 core categories and 12 associated themes in relation to participants' reports of their subjective experience of typical episodes of DSH. These are summarised in Table 1, together with illustrative quotes extracted from transcripts. It is important to note that some participants described typical episodes of DSH in general terms whereas others described individual episodes of DSH.

INSERT TABLE 1 HERE

Two distinct pathways to general episodes of DSH were identified during the selective coding stage; the Relief Pathway, consisting of a relief function and an expression of self-hatred secondary function and the Response to Mental Health Problems Pathway. Differentiation between pathways was related to the presence / absence of active symptoms of mental health problems. Participation within a dyadic suicide pact

emerged as a wholly unexpected theme from the analysis process and was therefore treated as a unique core category. Figure 1 depicts the temporal progression from one theme to another contained within participants' recollection of episodes of DSH.

INSERT FIGURE 1 HERE

The Relief Pathway was characterised by individuals ruminating (n=6) upon difficulties within their lives both past and present (n=2) and being unable to see a way out of these problems (n=2). The ruminating process was fraught with confusion and ambivalence (n=3) which individuals had to fight (n=2) in order to be able to self-harm. The final decision was often impulsive (n=3) and aided by the availability of means (n=7) to be able to self-harm. The availability of means to self-harm was central to the occurrence of episodes of DSH and a lack of available means to self-harm lead to some individuals planning episodes (n=4). Within the Relief Pathway, individuals employed self-harming behaviours primarily as a means of gaining relief from the ruminating process (n=4). DSH also functioned as an expression of self-hatred for two participants. These participants reported themes associated with the Relief Pathway in relation to these episodes and an associated sense of relief. Therefore, an expression of self-hatred was conceptualised as a secondary function of the Relief Pathway. Although not prompted directly for this information, participants described the experience of Relief following episodes of self harm as reinforcing and having an addictive quality which leads to increase in the frequency and severity of DSH (n=2).

The Response to Mental Health Pathway was characterised by the presence of positive symptoms of mental health problems (n=5), such as hearing voices instructing the individual to self-harm (n=2) or delusional thinking (n=3) in which DSH seemed to be a logical decision in light of the individuals' belief that they were being persecuted (n=1), that the world had ended (n=1) or that the bible favoured this course of action (n=1). For those that experienced auditory command hallucinations, there was an attempt to resist the voices by arguing with them (n=2). However, the voices were experienced as more powerful than the individual and so eventually the individual acquiesced to the command to self-harm in order to appease the voices. Again, the availability of means to self-harm directly led to episodes of DSH within this pathway (n=7).

Within the dyadic suicide pacts reported (n=2), the suicide partner was a woman who the participant had been romantically involved with and both participants indicated that their girlfriend had been the dominant partner who had first suggested the pact. Both participants had previously engaged in episodes of DSH which did not involve their pact partner.

For one participant, the pathway to the pact was closely associated with the Relief Pathway and a joint ruminating process:

"I don't think we had a like discussion before we did it sort of thing, and that was when we both slashed our wrists..... me and this girlfriend were both waiting to go to court. We both thought we would get sent down, we both had no money, we were having a

crap life at the time, so without giving it that much thought we both slashed our wrists”(Participant 1)

For the other participant, the pact was more in line with the Response to Mental Health Problems Pathway and in particular a joint delusional thinking process:

“The circumstances were that it was a very persecutory, delusional system, where myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that... we believed that when these people did get us, then they were going to really, really you know hurt us in bad ways you know. So we thought the best way would be just to have, it might sound strange, just a quick death you know, just get it out of the way you know, rather than be like tortured to death I remember it all came to a head one morning when we got ourselves in really quite a state you know and she suggested it. My mind recoiled it, I was trying to find some way out of it you know but the more, time progressed...and we kind of like couldn't see a way out of it, so that's why we did what we did”(Participant 4)

(See Appendix N for further details regarding these results and also results from additional research questions)

DISCUSSION

The present study is the first to explore causal pathways to episodes of self-harm as experienced by mentally ill men currently detained within a high secure hospital by interviewing patients directly. The only other study to examine self-harming behaviours within this specific population has focussed solely on prevalence rates and methods of self-harm using information gleaned from nursing case notes (Jackson, 2000).

The main finding of this study indicated a two-pathway aetiology of DSH among mentally ill men within a high secure hospital setting; the Relief Pathway and the Response to Mental Health Problems Pathway. Many participants had experienced both pathways over the course of their life. This suggests that it is essential that clinicians carefully assess the typical pathway which leads to episodes of self-harm for individuals in order to target specific components within the pathway for change. The robustness of the proposed dual-pathway to episodes of DSH within this population requires further research.

The Relief Pathway:

The Relief Pathway to episodes of typical self-harm was characterised by the presence of a ruminating process, involving difficulties in problem-solving and hopelessness, confusion, ambivalence and ‘fighting ambivalence’, with self-harm providing relief for the individual. This lends support to the notion that cognitive factors, such as difficulties in problem-solving and hopelessness play a critical role in the lead up to an episode of DSH (Williams and Pollock, 2000; Jollant et al, 2005). The Relief Pathway is hypothesized to consist of two inter-related functions; relief and an expression of

self-hatred. Thus, episodes of self-harm may serve multiple functions for mentally ill men. Consequently, treatment may need to target antecedent components of this pathway such as rumination, difficulties in problem-solving and hopelessness rather than the aiming to change the function of DSH.

Within the Relief Pathway, episodes of DSH functioned primarily as a means of gaining relief. This function closely resembles the affect-regulation model, described by Klonsky (2007). An expression of self-hatred served a secondary function within the Relief Pathway and is closely aligned with the self-punishment model also described in Klonsky (2007). Empirical support for a self-punishment or expression of self-hatred function of DSH has been inconsistent, with this function appearing to be a prominent motivation for DSH in some studies but not in others (Briere and Gil, 1998; Herpertz, 1995). It has been suggested that self-punishment may be a secondary reason for episodes of DSH, with affect-regulation being the primary reason (Klonsky, 2007). Findings from the present study add credence to this view and indicate that self-punishment may be a secondary function of the Relief Pathway which is associated with gaining relief from the act of self-harming. Gaining relief from DSH was found to have an addictive quality within this study and therefore lends credibility to Skegg's (2005) proposal that an affect-regulating or relief function of DSH may contribute towards a propensity for self-harming to become repetitive. This finding also supports Carter et al's (2005) findings in which increasing levels of severity were present in successive episodes of DSH.

The Relief Pathway identified within this study closely maps onto Huband and Tantum's (2004) 'Spring Pathway' which consisted of rumination, periods in which

individuals struggled between cutting and not cutting, the presence of an effort to resist cutting and cutting providing a relief; these factors are similar to the ruminating process, ambivalence, fighting ambivalence and relief components of the Relief Pathway described within this study.

The Response to Mental Health Problems Pathway:

The Response to Mental Health Problems Pathway was distinguished by the presence of positive symptoms of mental health problems which directly influenced episodes of self-harm. Therefore, treatment for those who typically experience this pathway may need to address positive symptoms of mental health problems. DSH as a response to active symptoms of mental health problems, such as auditory command hallucinations and delusions has received relatively little attention within the current evidence-base. Indeed, it was not even acknowledged in a recent review of the functions of DSH (Klonsky, 2007). This may be owing to researchers exploring DSH as a behavioural phenomena often focussing on those with a diagnosis of borderline personality disorder (Shaw, 2002).

A history of DSH has been reported in those who experience auditory command hallucinations within some studies (Simms et al, 2007; Lee et al, 2004) and the present findings appear to support this. Those who experienced auditory command hallucinations to self-harm attempted to resist the voices, a factor found within previous research (Simms et al, 2007). It has been suggested that the risk of acting upon command hallucinations is mediated by variables such as beliefs held about the power of the voice, the content of the instruction and the presence of a congruent delusion (Braham et al 2004). Therefore treatment addressing voices may need to

address such factors (Chadwick et al, 1996; Birchwood et al, 2000; Beck-Sanders et al 1997; Braham et al, 2004). Interestingly, those who heard voices instructing them to self-harm experienced multiple voices and it is possible that the presence of multiple voices increased the general pressure felt by the individual to comply with instructions to self-harm. Research evidence suggests that delusional beliefs may influence self-harming behaviours for some individuals (Fenton et al, 1997). The present study also found this to be the case. The delusional beliefs which influenced self-harming behaviours within the current study were complex. It has been suggested that the individuals' attributional style is an important factor which contributes to delusion formation (Garety et al, 2001) and thus it may be useful for treatment to target the attributional style of those whose delusional beliefs influenced their self-harm.

Pathways to Dyadic Suicide Pacts:

Participation within a dyadic suicide pact emerged unexpectedly as a core category from the analysis process as the study had set out to explore individual experiences of DSH. Due to the atypical nature of these events (Cohen et al, 1961; Brown et al, 1995), suicide pacts were afforded particular attention within this study. The finding of two pacts within a small sample of seven may suggest a higher incidence of participation within a suicide among mentally ill men in a high secure hospital. This requires further exploration. In both cases, the suicide partner was a woman who the participant had been romantically involved with. This is similar to other studies describing suicide pacts as typically involving a male and female partner (Brown et al. 1995). Participants who reported being involved in a suicide pact had previously engaged in DSH without their pact partner and this was also found to be the case in Brown et al's (1995) study. Both participants reporting this pathway indicated that their girlfriend had been the

dominant partner who had first suggested the pact. This differs from previous research which suggested that aggressive and depressed men, with a history of DSH typically convince a female partner to participate in a suicide pact (Rosenbaum, 1983; Rosen, 1981). It is possible that the men reporting participation within a dyadic suicide pact in the present study were aware that being seen as the dominant partner may have negative connotations and thus responded in a socially desirable manner to queries regarding who was the dominant partner within the pact. However, it is equally possible that the dominant pact partner was female.

For the individuals reporting participation within a suicide pact, the pathway and function of DSH closely mapped onto the Relief and the Response to Mental Health Problems Pathways. This supports previous findings that for some individuals the suicide pact was in response to delusional beliefs, whereas for others the purpose of the pact was to gain relief (Brown et al, 1995). Similar to Salih's (1981) case study, the present research highlighted the role of joint delusional thinking between pact partners, often referred to as a '*folie a deux*' within the literature, as directly leading to a suicide pact. The findings of the current study may lend some credibility to Salih's (1981) notion that for some, but not all, individuals a '*folie a deux*' may increase the probability of engaging in a suicide pact.

Other findings:

The decision to self-harm was often impulsive and the availability of means to engage in DSH was sufficient to trigger an episode. This is similar to research suggesting that over 50% of those that self-harm did not think of it for more than one hour prior to the episode (Williams & Pollock, 2000). Impulsivity and the presence of available means

to self-harm assisted in overcoming ambivalence regarding whether or not to self-harm for individuals experiencing the Relief Pathway. Research suggests that limiting the availability of means to self-harm leads to a reduction in DSH. In the year following legislation to reduce pack sizes for analgesics in the UK, the incidence rate of paracetamol overdoses dropped significantly (Hawton, 2004). Therefore, the findings of the current study supports the notion that reducing the availability of methods of self-harm is useful preventative intervention and is likely to lead to a reduction in impulsive acts of DSH.

The men within this study had all employed lethal means of DSH during at least one episode of DSH and used multiple methods of DSH over the course of their life (Murase et al, 2003; Heila et al, 1997; Herpertz, 1995). This may help to explain the elevated mortality risk amongst mentally disordered offenders (Bjork and Lindqvist, 2005). Similar to other studies exploring DSH in forensic populations, the participants within this study had an index offence of a violent as opposed to a sexual nature. Du Rand et al (1995) and Kerkhof and Bernasco (1990) independently found that prisoners charged with violent offences such as murder or manslaughter were more likely to engage in DSH than controls.

Methodological Limitations:

As with much qualitative research the sample size was small, naturalistic and non-random, however this approach was selected as the most appropriate to address the aims of the study. The sample consisted of mentally ill men within a high-secure hospital and this raises questions regarding the generalisability of the findings to other populations who self-harm such as women and those who have not been diagnosed

with schizophrenia. However the present findings are likely to be applicable to mentally ill men who self-harm in other settings, such as prison, in-patient psychiatric settings and within the community. The study relied heavily upon participants' verbal reports of mental activity, but did not seek evidence as to what actually occurred. Self-report studies have often been criticised as participants may have difficulty in verbalizing their motivations and so offer inaccurate explanations (Nisbett and Wilson, 1977). The self-report approach adopted within this study enabled in-depth exploration of participant accounts of DSH and had the advantage of reducing demand characteristics, as participants were not overtly asked to provide reasons for, or justify a behaviour, which is often seen as socially undesirable. The data may also be open to subjective biases in interpretation and coding as it was not possible to enlist an independent coder and establish inter-rater reliability. However, credibility checks were undertaken in order to enhance the trustworthiness of the findings.

Conclusions:

This study identified two major pathways to DSH within mentally ill men in a high secure hospital; the Relief and the Response to Mental Health Problems Pathway. Further research is required to substantiate this two-pathway model of DSH within mentally ill men. Differing pathways to episodes of DSH indicate different treatment needs, for example those who experience the Response to Mental Health Problems Pathway may derive benefit from interventions which directly address positive symptoms of their mental health problems, whereas interventions addressing cognitive style and difficulties in problem-solving may be more suited to those who experience the Relief Pathway.

Participation within a dyadic suicide pact emerged as a wholly unexpected theme within this study and it is possible that there is a higher incidence rate of participations within these atypical events amongst mentally ill men in high secure hospitals. The two suicide pacts reported closely mapped onto the Relief and Response to Mental Health Problems Pathways, suggesting that mental health problems may play a role in some suicide pacts but not others

Previous studies exploring motivations and functions for self-harming behaviours have tended to employ a checklist method, in which individuals endorse items relevant to their experience (NICE, 2004; Klonsky, 2007). Functions of DSH identified within the literature may appear to be distinct owing to the methodology employed. By exploring pathways to episodes of self-harm, the present study found that functions of DSH which had previously been conceived of as distinct and independent followed a similar causal route within the Relief Pathway. Therefore, future research needs to explore causal pathways experienced by those that self-harm in greater detail. The present study also indicates that clinicians treating individuals who engage in self-harming behaviours need to carefully assess each individual episode of DSH as pathways to DSH may differ within individuals across episodes and DSH may serve multiple functions within a single DSH episode (*see Appendix O for an extended discussion*).

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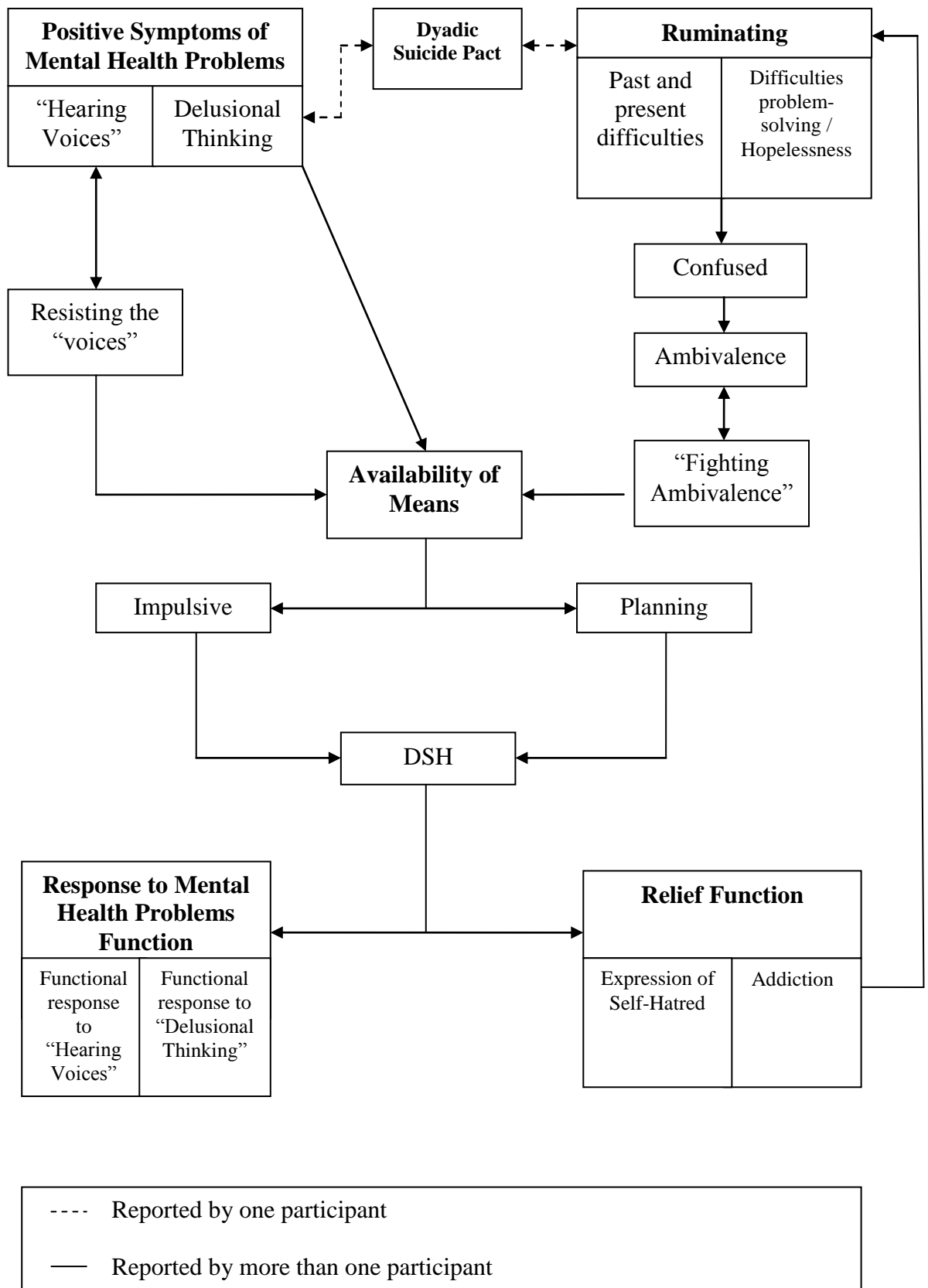
Table 1 – Themes and categories derived from participants’ recollections of typical episodes DSH

Core Category	Theme	Exemplar Quotes.
Availability of Means (n=7) (1,2,3,4,5,6,7)		“it’s having the means to do it, to self harm” (participant 2)
	Planning (n=4) (2,4,6,7)	<p>“I might not be able to do it straight away so I have to plan it and sort of organise it so that I can do it when I’m ready” (participant 2)</p> <p>“There can be quite a great deal of planning, certainly in my experiences” (participant 4)</p>
	Impulsive (n=3) (1,3,5)	<p>“I think each time has been sort of on the spur of the moment you know, so I’ve not really given it a lot of thought” (participant 1)</p> <p>“sometimes it’s like impulsive” (participant 5)</p>
Ruminating (n=6) (1,2,3,4,5,6)		“I think to myself, ‘I’ve got nothing to live for, what have I got to live for, I don’t know what I’ve got to live for. Who’d be bothered if I was dead or not’. So at the time you’re thinking ‘I’d be better off dead” (participant 1)
	On Past and present difficulties (n=2) (3,5)	“my mind’s working overtime....how the family is, or how life was, what I used to have, what I didn’t have, what I should have had and what I could have had and to what I’ve got then I do it.” (participant 3)
	Confused (n=2) (4,6)	<p>“Absolute confusion.....persistent confusion” (participant 4)</p> <p>“Feeling very confused” (participant 6)</p>
	Difficulty in problem-solving / Hopelessness (n=2) (3,4,5)	“When I’ve wanted to kill myself, that’s when I’ve had no hope left. That’s when I’ve cried through a lot of it and that’s when I’ve thought well I can’t see no end to the problem.” (participant 3)
	Ambivalence (n=3) (2,4,5)	“I did kind of think “what I’m I doing this for, you know? Just why am I doing this? Is life really this bad that it’s come to this? There must be some better way to deal with things?” (participant 4)
	Fighting Ambivalence (n=2) (4,5)	“Because there is a part of you when, when you actually attempting suicide that says “I don’t want to do this I really don’t want to do this” and you have to fight that to actually attempt it” (participant 4)

Table 1 – Themes and categories derived from participants’ recollections of typical episodes DSH continued

Core Category	Theme	Exemplar Quotes.
DSH in direct response to positive Symptoms of Mental Health Problems (n=5) (2,3,4,7)	Delusional thinking (n=3) (2,4,7)	“I started to get a message from the bible and I had to check it a again and again every fortnight for a while....and it was the same message that told me I had to circumcise myself” (participant 7)
	Hearing Powerful Voices (n=2) (3,7)	“Sometimes the voices are too much for me to control.” (participant 3)
	Resisting the Voices (n=2) (3,7)	“[The voices] told me to put a plate through the window. They just kept on and onand I argued with them saying like “You know I can’t do that really”. That went on for quite a while... I finally did it” (participant 7)
Relief (n=3) (1,3,4)		“It would be a relief at the time, because at the time I was depressed and I was worrying and everything, so it would have been a relief from that at the time.” (participant 1)
	Expression of Self-Hatred (n=3) (3,4)	“It’s just a weird way of dealing with anger and hatred and self-loathing that I felt. It was a moment of relief for me.” (participant 4)
	Addiction (n=2) (3,4)	“I’ve been like addicted to the feeling....it brings you back down to your normal way of thinking”; (participant 3) “It [DSH] began with once a week and gradually it was every other day and then, you know, every day. It was getting more frequent and it was getting more severe” (participant 4)
Dyadic Suicide Pact (n=2) (1,4)		“me and this girlfriend were both waiting to go to court. We both thought we would get sent down...so without giving it that much thought we both slashed our wrists”; (participant 1) “myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that.” (participant 4)

Figure 1 – Temporal progression from one theme to another contained within participants’ recollection of general episodes of DSH.



APPENDIX A

INSTRUCTIONS FOR AUTHORS SUBMITTING TO THE JOURNAL OF FORENSIC PSYCHIATRY AND PSYCHOLOGY

Submission

Authors should submit their paper electronically, to Professor Conor Duggan at forensic-psychiatry@nottingham.ac.uk. Electronic submissions should be sent as email attachments using a standard word processing program, such as MSWORD. If email submission is not possible, please send an electronic version on disk along with three paper copies together with one set of high quality figures for reproduction.

Legal submissions should be sent to Dr Bridget Dolan, 3 Serjeants' Inn, London EC4Y 1BQ. Bridgets: bdolan@3Serjeantsinn.com

Correspondence and Book Reviews to Dr Simon Wilson, Assistant Editor (Psychiatry) & Book Review Editor, Journal of Forensic Psychiatry & Psychology, Consultant Forensic Psychiatrist and Honorary Senior Lecturer, Department of Forensic Mental Health Science, Institute of Psychiatry, De Crespigny Park, London SE5 8AF.

It will be assumed that authors will keep a copy. Submission of a paper to the journal will be taken to imply that it presents original, unpublished work not under consideration for publication elsewhere. By submitting a manuscript, the authors agree that the exclusive rights to reproduce and distribute the article have been given to the publishers, including reprints, photographic reproductions, microfilm, or any other reproductions of a similar nature, and translation.

The submission should include for each author, name, degrees or other qualifications, position or affiliation, the department where the work was done and an address for correspondence with post code.

The manuscript

Submissions should be in English, typed in double spacing with wide margins, on one side only of the paper, preferably of A4 size. Articles should normally be between 3,000 and 8,000 words in length and preceded by an abstract of less than 200 words.

The abstract should be followed by six key words. Any notes or footnotes, tables and figures should not be inserted in the pages of the manuscript but should be on separate sheets. Tables and figures should be numbered consecutively in Arabic numerals with a descriptive caption. The desired position in the text for each table and figure should be indicated in the margin of the manuscript. Permission to reproduce copyright material must be obtained by the authors before submission and any acknowledgements should be included in the typescript or captions as appropriate. If possible a word count should be provided.

Photographs

Photographs should be high-contrast black and white glossy prints and have an explanatory legend. Permission to reproduce them must be obtained before submission, as for tables and figures.

Case Report

Case reports should be accompanied by the written consent of the subject. If a subject is not competent to give consent the report should be accompanied by the written consent of an authorized person.

References

The journal's reference style is APA. The APA system uses the name of the author and the date of publication as a key to the full bibliographical details which are set out in the references.

When an author's name is mentioned in the text, the date is inserted in parentheses immediately after the name, as in 'Dell(1982)'. When a less direct reference is made to one or more authors, both name and date are bracketed, with the reference separated by a semi-colon, as in 'several authors have noted this trend (Griew, 1984; O'Donovan, 1984; Ashworth, 1987)'.

When the reference is to a work of dual or multiple authorship, use only surnames of the abbreviated form, as in 'Friar and Matthews (1980)' or 'Fisher *et al.*(1974)'.

If an author has two references published in the same year, add lower case letters after the date to distinguish them, as in 'Bullard (1980a, 1980b)'.

For direct quotations of 40 words or more, which will be printed as prose extracts, page numbers are required. Always use the minimum number of figures in page numbers, dates etc., e.g. pp. 24-4, 105-6 (but using 112-13 for 'teen numbers) and 1968-9.

Format of reference lists and bibliographies

Submissions should include a reference list in alphabetical order whose content and format conform to the following examples. Note: elements of information are separated by a full stop; authors' names are given in full; page numbers are required for articles in readers, journals and magazines; where relevant, translator and date of first publication of a book, and original date of reprinted article, are noted.

Book

Walker, N. (1977) *Behaviour and Misbehaviour: Explanations and Non-explanations*.
Oxford: Blackwell.

Multiple author

Gibbens, T. C. N. and Prince, J. (1962) *Shoplifting*.
London: Institute for the Study and Treatment of Delinquency.

Two references in same year/translated text

Jaspers, K. (1963a) *General Psychopathology*, 7th edn. Trans. Hoenig, J. and Hamilton,
M. Manchester: Manchester University Press.

Article in edited Volume

Pernanen, K. (1976) 'Alcohol and Crimes of Violence'.
In Kissen, E. and Begleiter, H. (eds) *Biology of Alcoholism*, Vol 4, *Social Aspects of
Alcoholism*. New York: Plenum Press, pp. 176-92.

Article in journal

Wong, M. and Singer, K. (1973) 'Abnormal Homicide in Hong Kong'. *British Journal
of Psychiatry* 123: 295-8.

Article in Newspaper

The Observer (1985) 'The Obscene Telephone Caller'. 1 September 1985: 35.

Law reports should be in a separate list arranged alphabetically.

Law reports

In reference to law reports in the text care should be taken to distinguish between round
and square brackets.

From the year 1891 onwards and where there is more than one volume per year the date is placed in square brackets: eg *DPP v Camplin* [1978] in the text and *DPP v Camplin* [1978] 1 AL ER 168 in the legal reference list.

For cases before 1891 and where volumes are serially expressed the date is in round brackets: e.g. *R. v Dix* (1982) in the text and *R. v Dix* (1982) 74 Cr App R 306 in the reference list.

The title of law reports is underlined to indicate that it will appear in italics. (The 'v' is in Roman.) Where there is a volume number it follows the brackets. An abbreviated form of the source of the law report follows, and then the page reference.

Legislation

Acts of Parliament and other legislation are referred to in the text only and appear in their shortened form: e.g. Mental Health Act 1959, with no comma before the date.

Proofs

Page proofs will be sent for correction to a first-named author, unless otherwise requested. The difficulty and expense involved in making amendments at the page-proof stage make it essential for authors to prepare their typescripts carefully: **any alteration to the original text is strongly discouraged**. Authors should correct printers' errors **in red**; minimal alterations of their own should be in **black**. Our aim is rapid publication: this will be helped if authors provide good copy, following the above instructions, and return their page proofs to the editor on the date requested.

APPENDIX B

EXTENDED BACKGROUND LITERATURE REVIEW

INTRODUCTION TO DSH

Deliberate self-harm (DSH) constitutes a major public health problem in the UK. Presentations of DSH to accident and emergency (A & E) departments are common, with over 150,000 annually (Yeo, 1993) and evidence suggests that self-harming behaviours are becoming increasingly prevalent (Zlotnick et al, 1999; Briere & Gil, 1998; House et al, 1998). A national survey suggested that between 4.6% and 6.6% of individuals in Great Britain have self-harmed at some point over the course of their life (Meltzer, et al., 2002a). First episodes of self-harm tend to occur between 14 and 24 years old (Favazza & Conterio, 1989; Herpertz, 1995). Individuals who self-harm are known to be statistically at a much higher risk of completed suicide than the rest of the population (Hawton et al, 1998) and they frequently report that services fail to meet their needs (Arnold, 1995; Harris, 2000). With the risk of repetition and completed suicide high (Owens et al, 2002; Cooper, et al, 2005; Suominen et al, 2004); DSH poses a considerable financial burden to the NHS. Therefore, research focused on the development and function of DSH and patient perception of interventions is of critical importance.

DSH remains a taboo subject within society about which negative attitudes, fears and myths regarding these behaviours continue to permeate (Linehan, 1993; Vivenkanada, 2000; McAllister, 2003). This may be owing to the notion that intentionally causing harm to oneself is in direct opposition to the basic human drive of self-preservation (McAllister, 2003). Societal attitudes regarding self-harm may prevent individuals

who engage in DSH from disclosing their behaviour to others (Horesh et al, 2004) and many episodes of DSH do not reach the attention of services or professionals; instead wounds are often treated in private by the individual (Mental Health Foundation, 1997). When incidents of DSH are made known to professionals they may not be recorded as such. Professionals may attempt to protect the client from associated stigma (McAllister, 2003) or episodes of self-harm may be incorrectly attributed to spousal abuse or accident (Taylor & Cameron, 1998). Thus, statistical information concerned with the incidence and prevalence of DSH may be presently underestimated within the current literature.

There is much literature concerned with DSH as a behavioural phenomenon and it has been argued that much of our current knowledge is skewed towards white women with a diagnosis of borderline personality disorder (Shaw, 2002). A number of studies have narrowly focussed on DSH within this population (Linehan, 1993; Dubo et al., 1997; Low et al., 2001; Brown et al, 2002; Shearer, 1997). However, being male with a diagnosis of schizophrenia and multiple episodes of DSH has been predictive of subsequent completed suicide (Zahl & Hawton, 2004; Meltzer et al, 2002a) and at present there is a paucity of literature concerned with repetitive DSH within this population.

Terminology: Attempted Suicide or Self-harm?

It would be erroneous to discuss DSH without some comment on the terminology and classification debate pervading the field. Historically, individuals who deliberately self-harmed but survived the experience were referred to as “failed suicides”. However, during the 1960s the admission rate for these failed suicides rose and it became

increasingly clear that many of these individuals did not want to die (Skegg, 2005). This was supported by studies highlighting that many who self-harm do not have suicidal thoughts or want or indeed expect to die (Osuch et al, 1999; Douglas et al, 2004). Consequently, it has been proposed that the crucial distinction between attempted suicide and self-harm is the presence or lack of suicidal intent; with people who attempt suicide wanting to kill themselves, whilst no such motive exists within those who self-harm (Shea, 1993; Osuch et al 1999; Bunclark & Adcock, 1996).

Skegg (2005) furthered this view, describing the distinction between self-harm and attempted suicide in terms of the lethality of the method employed. Within Skegg's (2005) conceptualisation, behaviours such as hanging, stabbing and electrocution are seen as traditional methods of attempted suicide, whereas, scratching, burning, cutting and interfering with wounds are viewed as self-harming owing to the low risk of mortality. Haw et al (2003) found supporting evidence for Skegg's (2005) proposal, demonstrating a positive association between suicidal intent and lethality of method. In addition to differences in suicidal intent and lethality of method, differences in age and sex distribution for completed suicide and self-harm have been found (Williams & Pollock, 2000). For some theorists, this has been sufficient evidence to suggest the need for different aetiological models for these behaviours (McAllister, 2003).

Although distinguishing between self-harm and attempted suicide according to suicidal intent appears to have good face validity, studies have revealed that individuals who engage in DSH habitually report mixed intentions regarding their DSH (Schnyder et al, 1999). Furthermore, it has been argued that differences in age and sex distribution do not necessarily imply that these are separate phenomena requiring discrete explanatory

frameworks (Williams & Pollock, 2000). Indeed, there appears to be much overlap between these concepts. Approximately 40% of persons who go on to successfully kill themselves have a history of self-harm irrespective of suicidal intent during the episode (O'Connor & Sheehy, 2000). Consequently, it has been recommended that self-harm and suicide be considered along a continuum of suicidal behaviour (O'Connor & Armitage, 2003) and that any differences between suicide and self-harm have been overstated (Williams & Pollock, 2000).

In line with the continuum of behaviour view of DSH, the National Institute of Clinical Excellence (NICE, 2004) guidelines regarding self-harm do not distinguish between suicide attempts and self-harm, employing the term deliberate self-harm to describe a spectrum of behaviours in which individuals engage in “self-poisoning or self-injury, irrespective of the apparent purpose of the act” (NICE, 2004, p.7). The present study adopts this definition and used the terms “DSH” or “self-harm” to refer to behaviours previously described in research as attempted suicide, parasuicide, self-poisoning, self-wounding, self-injury and self-mutilation (Klonsky, 2007; Favazza, 1992; Linehan, 1993; Tantam & Whittaker, 1992) and the term “suicide” to refer to acts of DSH which have resulted in death.

Methods of DSH

Methods of self-harm can be divided into two broad groups; self-poisoning and self-injury. Self-poisoning refers to purposeful ingestion or injection of toxic substances into the body with the desire to cause self-harm and self-injury describes the intentional damaging body tissue (Skegg, 2005). Approximately 80% of people who present to A & E following DSH will have taken an overdose (Horrocks et al., 2003). However,

self-injury is more common than self-poisoning in the population as a whole, perhaps by a ratio of two to one in adolescents (Hawton et al., 2002). Skin-cutting is the most common form of self-injury (Klonsky, 2007; Hawton et al, 2002; Horrocks et al., 2003), occurring in 70-97% of individuals who self-harm, followed by banging or hitting (21-44%) and burning (15-35%) (Briere & Gil, 1998; Favazza & Conterio 1989; Klonsky, 2007). Less common methods of DSH include hanging, autocastration, inserting objects into the body, and swallowing objects among others. Several studies report that the majority of individuals who engage in self-harming behaviours have used multiple methods (Herpertz, 1995; Gratz, 2001; Favazza & Conterio, 1989).

Repetitive DSH

Approximately 15% of individuals presenting with DSH at general hospitals will be seen again within a year at hospital (Owens, et al, 2002) and a greater proportion will repeat the act without presenting to professionals again (Guthrie et al, 2001). The reported estimates of lifetime episodes of DSH range from 3.4 episodes to 50 (Soloff et al., 1994; Favazza & Conterio, 1989). Repetitive self-harmers are known to comprise a particularly high-risk group for completed suicide (Sakinofsky, 2000; Owens et al, 2002; Cooper, et al, 2005; Suominen et al, 2004). It is clear that immediate intervention with this population is necessary as the risk of fatal repetition is highest following the initial episode. Within a Chicago-based study, Maris (1992) found that 70% of subjects died during their first attempt, 14% during the second episode, thereafter the proportions dropped sharply and tailed off with each successive episode. Similar findings were reported in the Finish National Suicide Project (Isometsa & Lonnqvist, 1998), in which half of the 1397 subjects died during their first attempt, a further one-fifth during the second episode, one-tenth during the third episode and the remainder in

the subsequent episodes. It is important to note that, both studies relied upon a psychological autopsy method, in which data is gathered post-suicide from medical records, coroners' records and relatives of the suicide victims and thus are open to informant bias which adversely affects the internal validity of their findings.

Numerous univariate and multivariate studies have identified factors which may predict repetitive DSH such as age, alcohol abuse, being unmarried, criminal record, depression, hopelessness, hostility, poor-problem solving, powerlessness, previous attempts, psychiatric history, separation from parents and sexual abuse, (Sakinofsky & Roberts, 1990; Kreitman & Foster, 1991; Scott et al, 1997; Buglass & Horton, 1974; Hjelmeland, 1996). The number of predictive variables for repetition highlights the heterogeneous nature of antecedents to episodes of self-harm and indicates that pathways to episodes of DSH may well vary significantly in terms of onset, method, development, function and meaning between individuals.

A 'Kindling' or 'Behavioural Sensitisation' theory has been proposed by Pettit et al (2004) as a conceptual aid for repetitive non-fatal DSH. The authors proposed that lower levels of stress are required to trigger successive episodes of increasingly severe and lethal DSH. An Australian study conducted by Carter et al (2005) employed a nested case-control research paradigm, and identified patients who had been treated on more than one occasion for self-poisoning who had subsequently committed suicide and those who had not died by suicide. The controls were matched for gender and age. They found increasing levels of severity in preceding episodes of self-poisoning in individuals who later committed suicide, thus lending credence to the behavioural sensitisation theory. However, there were some limitations inherent within Carter et

al's (2005) work which requires careful consideration. Differences in follow-up time between the cases and controls and the possibility that some deaths within the control group may have been misclassified as non-suicides owing to a lack of detail surrounding the death raises questions regarding the validity and reliability of their findings.

Suicide Pacts

Although habitually conceptualised as a personal and private act, DSH and suicide sometimes involves pairs of victims and even large groups. Suicide pacts have been conceptualised as a mutual arrangement between two or more people, to kill themselves simultaneously (Cohen, 1961). In one form of dyadic suicide pact, death is agreed upon and both parties act independently; in another type, one person in the pair coerces the other person into carrying out the behaviour. The latter type is thought to encompass the majority of pacts (Rosen, 1981; Fishbain et al, 1984). Hemphill and Thornley (1969) were the first to detail the strong union between those involved in a suicide pact, which they termed "the encapsulated unit". Members of this "unit" become isolated from society, communicating only with their partner. In situations in which this interdependent unit is threatened with dissolution, the pair settles upon dying together rather than be separated (Fishbain et al, 1984). Arguably, the most important element of the pact dynamic is the influence of the dominant member of the pair over the submissive partner. Studies have suggested that one of the pact pair is usually the instigator who coerces the other into DSH. Interviews with pact survivors typically depict an aggressive, depressed man with a history of DSH, who convinces his female partner to commit suicide with him (Rosenbaum, 1983; Rosen, 1981).

Suicide pacts are atypical events within DSH and thus are difficult to study in detail, consequently, there is little related literature. The largest study of suicide pacts remains Cohen's (1961) seminal work which explored 58 suicide pacts in England between 1955-1958. Within this study death following a suicide pact accounted for less than 0.6% of all deaths by suicide during this period. According to Cohen (1961) suicidal pacts rarely miscarry and this may help to explain why suicide pacts are often studied following the death of the individuals involved, traditionally using the psychological autopsy method. A more recent study by Brown et al, (1995) identified nine suicide pacts from coroner's records of 722 consecutive suicides between 1974-1993, in order to determine the incidence of suicide pacts per 100 suicides and to give an account of the demographic, medical and psychiatric aspects, as well as assess the motivation for these pacts. Information extracted from coroner's inquest notes and medical and psychiatric records provided information regarding the period before death and the salient features of the person's medical and psychiatric histories. Evidence regarding the mental health states of participants was obtained from medical and psychiatric reports or from oral or written statements by relatives, which allowed the researchers to assess each case as mentally ill or mentally well according to DSM-III-R criteria.

Brown et al (1995) found that 18 (2.5%) of the 722 suicides within the time period they studied had occurred within the context of a suicide pact. Each dyadic suicide pair was comprised of a male and a female partner who died in the same place, on the same day and by the same method. The nine men were aged between 28-81 years (mean 54 years) and the nine women were between 21-82 years old (mean 54 years). Nine subjects were mentally ill at the time of death and two were probably mentally ill. At least one person within the dyadic pact was mentally ill at the time of death. Of these

11 subjects, nine had a major depression, one had a generalised anxiety disorder and the other was alcohol-dependant and depressed. Five of the 18 subjects were under the care of a psychiatrist and four had previously seen a psychiatrist. Five had a history of DSH, but none jointly with the person they later died with. In the seven pacts between married couples, the motive for suicide in one partner resembled that for a single suicide with the other person committing suicide by virtue of the mutually dependant nature of their relationship. Six of the seven married couples reportedly had few friends and visitors. Within the seven marital pacts the apparent motive for completed suicide was for the “relief of mental disorder” in four cases, “relief from pain” in two cases and “euthanasia”. In the remaining two pacts between unmarried couples, the motive appeared to be related to acting on delusional beliefs and in the other case there was no evidence found to indicate a particular motive. There were a number of methodological problems with this study. Firstly, two sets of consecutive suicides were amalgamated owing to changes in the area of the coroner’s jurisdiction during the time-period studied and it is important to note that the second series consisted of a larger geographical area and population, affecting the internal validity of the study. Secondly, motivation and antecedents to the pact were identified through third party information, rather than directly from subjects and thus it is possible that this study assessed third party perception of the motivation for suicide rather than the victims’ actual motivation for the behaviour. These methodological difficulties, in addition to the small sample size raise questions regarding internal and external validity of the findings.

Salih (1981) described a case involving a suicide pact between two women in which a mental disorder, a folie a deux, appeared to play a significant role and directly led to

joint DSH. A folie a deux is a relatively uncommon syndrome (Salih, 1981), which has been defined as “the transference of delusional ideas and / or abnormal behaviour from one person to one or more individuals who have been in close association with the primary affected person” (Gralnick, 1942). Situations of shared delusional beliefs may lend themselves well to suicide pacts (Salih, 1981). Although Salih’s (1981) case report and Brown et al’s (1995) study suggests that mental disorder may be an antecedent to suicide pacts, some researchers have queried the importance of such an association stating that mental disorder within a suicide pact is of less significance than within single suicides (Hemphill & Thornley, 1969; Fishbain et al, 1984). Hemphill and Thornley (1969) presented five pacts in which mental illness did not appear to feature. However, it is important to note that they did not examine medical and psychiatric records to verify their findings and thus it is possible that mental illness was undetected due to difficulties inherent within their research design.

PATHWAYS AND FUNCTIONS OF DSH

Within this study the term ‘function’ will be used to describe the purpose served by DSH and the term ‘pathway’ to describe the distal and proximal antecedents leading to acts of DSH. A number of researchers have argued that professionals who have contact with those who self-harm must understand the individual’s pathway to self-harm, in terms of its development and function, as this is likely to influence the choice of an appropriate intervention and its perceived helpfulness by the patient (Huband & Tantam, 2004; McAllister, 2003). Huband and Tantam (2004) explored repeated self-wounding among 10 women admitted to a general psychiatric hospital and identified two major pathways to self-wounding which they termed ‘The Spring’ and ‘The

Switch' pathways. The 'Spring Pathway' was defined by rumination and an unpleasant emotional state which intensified overtime until it became intolerable. Within the 'Spring Pathway' individuals experienced periods in which they resisted cutting, self-wounding provided short-lived relief for these individuals, Huband and Tantam's (2004) 'Switch Pathway' was characterised by the sudden appearance of a craving to cut which was acted upon. Individuals who experienced the 'Switch Pathway' tended to have a greater number of lifetime episodes of self-wounding.

Research exploring the developmental factors and functions of self-harm has generally employed a checklist method approach (NICE, 2004; Klonsky, 2007), in which individuals endorse items they deem to be relevant to their experience of DSH. Although the checklist method is a useful tool in bringing order and simplicity to complex phenomena, it may be limited in extending our knowledge of repeated DSH as individuals may self-harm on different occasions for different reasons (Horrocks et al., 2003). Therefore, studies in which participants discuss their experience through a series of open-ended questions may offer valuable insights into the antecedents and functions of DSH (Klonsky, 2007). In 2004, NICE recommended rigorous qualitative research be undertaken to explore patient experiences of episodes of DSH particularly in under researched groups. Major failings of the current NICE guidelines are that it does not take into account the longer-term care of people who self-harm nor does it consider issues relating to those that self-harm repeatedly or those who have engaged in DSH as part of a suicide pact. The present study addressed the NICE recommendations and also the failings identified.

Differing pathways to DSH may suggest different interventions needs and a recent review of 18 studies of the functions of DSH suggests that DSH may function in one or more of the seven following ways; affect-regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal-influence, self-punishment and sensation-seeking (Klonsky, 2007). The central themes and supporting evidence for these models are discussed below and represented in Table 2.

Table 2 - Functions of DSH as described in Klonsky (2007).

Function	Description of Function
Affect-Regulation	To alleviate acute negative affect or aversive arousal
Anti-Dissociation	To end the experience of depersonalisation or dissociation and generate the feeling of being alive or real again.
Anti-Suicide	To replace, compromise with, or avoid the impulse to commit suicide
Interpersonal Boundaries	To assert one's autonomy or a distinction between self and other
Interpersonal-Influence	To seek help from or manipulate others
Self-Punishment	To derogate or express anger towards oneself
Sensation-Seeking	To generate exhilaration or excitement

The Affect-Regulation Model

Within the affect-regulation model, DSH is conceptualised as a means of alleviating negative affect or physiological arousal. Linehan (1993) furthered this view and proposed that an early invalidating environment may inhibit learning healthy coping strategies for dealing with emotional distress. Individuals from these environments and / or with a biological predisposition for emotional instability struggle to manage their emotional responses and are thus prone to employ DSH as a maladaptive affect-regulation technique. How DSH diminishes negative affective states is unclear, but

researchers have proposed both psychological (Brown et al, 2002; Suyemoto, 1998) and biological (Russ et al, 1994) mechanisms. An affect-regulating function of DSH may contribute to the propensity for DSH to become repetitive (Skegg, 2005).

The affect-regulation functional model of DSH has gained support within the evidence-base. In a study of 75 women with borderline personality disorder, Brown et al (2002) found that 96% of participants endorsed reasons indicative of self-harm serving an affect-regulation function. Similarly, in another study of women with borderline personality disorder, affect-regulation received the second highest mean rating out of 17 possible reasons for DSH (Shearer, 1994). Reasons consistent with affect-regulation have also been found in non-borderline samples. In a study by Herpertz (1995) exploring self-harm within a general psychiatric inpatient population, 76% of the sample endorsed “tension release” as a reason for DSH. In another inpatient study, reasons related to affect-regulation received substantially higher ratings than reasons associated with other functions of DSH (Osuch et al, 1999). In a mixed sample of psychiatric inpatients and outpatients who engaged in DSH, 80% indicated that they had previously self-harmed as “a distraction from painful feelings, 77% to “manage stress”, 77% to “release pent up feelings” and 75% to reduce tension (Briere & Gil, 1998). There is also physiological evidence in support of this model which suggests that those who self-harm experience a reduction in tension following a DSH episode (Brain et al, 1998).

The Anti-Dissociation Model

The Anti-Dissociation model characterizes DSH as strategy to end periods of dissociation or depersonalisation, which in turn, generates feelings of being alive or

real again. Researchers have suggested that individuals who self-harm experience dissociative episodes when separated from loved ones or as a result of intense emotions (Gunderson, 1984; Zlotnick et al, 1999). Causing physical harm to oneself is proposed to shock the system, perhaps through the sight of blood (Simpson, 1975) or the physical sensation (Gunderson, 1984), and thus ends the feelings of dissociation for the individual.

The current evidence-base exploring an anti-dissociation function for DSH has had mixed results. In women with borderline personality disorder, reasons related to anti-dissociation / “feeling generation” were endorsed by 54% of the sample (Brown et al, 2002). Similar results have been found within community samples, in which 55% of participants selected the reason “to feel real again” (Favazza & Conterio, 1989) and within a sample of incarcerated adolescent self-harmers, 60% endorsed the reason “to feel something even if it is pain” (Penn et al, 2003). Others studies have found less support for an anti-dissociative function for DSH. Herpertz (1995) found only 9% of psychiatric inpatients endorsed items suggesting this function and similarly, Shearer (1994) found only 7% of an inpatient sample of women with a diagnosis of borderline personality disorder considered an anti-dissociative effect to be one of their top three reasons for DSH.

The Anti-Suicide Model

The anti-suicide model views DSH as a mechanism for resisting urges to attempt suicide. Within this framework DSH is a means of expressing suicidal ideation without the associated risk of mortality and thus serves as a compromise with the desire to commit suicide (Suyemoto, 1998; Himber, 1994). Modest evidence indicative of an

anti-suicide function for DSH has been found by some studies. In a sample of women with borderline personality disorder, the reason “to prevent me from acting on suicidal feelings” received the seventh highest mean rating of a possible 17 reasons (Shearer, 1994). In an adolescent psychiatric sample, just under half of the participants selected to “stop suicidal ideation or attempts” from a checklist (Nixon et al 2002).

Interpersonal Influence Model

The interpersonal influence model was the theoretical explanation of choice for many early researchers exploring DSH (Allen, 1969; Bachman, 1972). Within this behavioural model, DSH is conceived of as an attempt to influence or manipulate others, a cry for help, a means of avoiding abandonment, or otherwise affect the behaviour of others (Allen, 1995). The response generated in others by the DSH, such as affection, is thought to be positively reinforcing. As Klonsky (2007) pointed out, the individual who engages in DSH for these reasons may not be aware of the reinforcement provided by responses to their self-harm and thus the behaviour may not be consciously manipulative.

Although a number of studies have explored reasons indicative of an interpersonal influence function of DSH (Brown, et al, 2002; Briere & Gil, 1998; Herpertz, 1995; Jones et al, 1979; Kumar et al, 2004; Nixon et al, 2002; Nock & Prinstein, 2004; Osuch et al, 1999; Shearer, 1994), only one has found strong evidence for this function (Brown, et al, 2002). In Brown et al’s (2002) study of DSH within a female borderline personality disordered sample, 61% endorsed reasons related to an interpersonal influence function. This function was less evident in other studies. Shearer (1994) found only 17% of women with borderline personality disorder selected “to seek

support and caring from others” and only 5% selected “to control the reactions and behaviour of others” as one of their top three reasons for engaging in DSH. Similarly, Herpertz’s (1995) study found 24% of an inpatient sample endorsed a “longing for care and attention” as a function of their DSH.

The Interpersonal Boundaries Model

The interpersonal boundaries model of the function of DSH draws heavily upon object-relations theory (Klonsky, 2007). Within this framework, individuals who self-harm are thought to lack a normal sense of self due to insecure maternal attachments and a subsequent inability to individuate from the maternal figure (Suyemoto, 1998; Friedman et al, 1972). Marking skin is thought to affirm a distinction between oneself and others and assert one’s identity and autonomy. Modest evidence has been found in support of the interpersonal boundaries model. Shearer (1994) found that the reason “to do something that only I have control of and no one else can control” control was rated as one of the top three reasons for DSH by 22% of a sample of women with borderline personality disorder. Likewise, Briere and Gil (1998) reported that 26% of psychiatric patients endorsed “ownership of body” as a motivation for DSH.

The Self-Punishment Model

The self-punishment model suggests that DSH is an expression of anger or derogation towards oneself. A number of researchers have reported self-directed anger and self-derogation as prominent features in those who self-harm (Herpertz et al, 1997; Soloff et al, 1994; Klonsky et al, 2003). Empirical support for the self-punishment model has been inconsistent. In a sample of women with borderline personality disorder, the item, “to punish myself for being ‘bad’” received the highest mean rating out of 17 possible

reasons (Shearer, 1994). In another study focussed again on women with borderline personality disorder, 63% indicated that self-punishment was a reason for their DSH (Brown et al, 2002). Similarly, 83% of participants in a mixed sample of psychiatric patients selected “self-punishment” as a reason for DSH (Briere & Gil, 1998). Support for this function of DSH also comes from studies exploring impulsivity, anger, hostility and DSH (Apter et al, 1993; Evans et al, 1996; Maiuro et al, 1989) suggest that the manner in which people who self-harm express anger and hostility tends to be more intro-punitive and covert, with high levels of guilt and depression. However, in a sample of inpatient self-harmers, reasons associated with “self-hatred and self-punishment” were only endorsed by just over 10% of participants (Herpertz, 1995) and in a sample of in-patient adolescents self-harmers, only 32% selected the reason “to punish yourself” (Nock & Prinstein, 2004). In two additional studies of psychiatric inpatients, one focussed on adults (Osuch et al, 1999) and the other on adolescents (Kumar et al, 2004), reasons suggesting self-punishment as a reason for DSH received substantially lower ratings than those suggesting an affect-regulation function.

Although it remains unclear at present as to why self-punishment appears to be a more prominent reason in some studies and not so in others, recent research conducted by Klonsky (2006, cited in Klonsky, 2007) may shed some light on this issue. Within this study, young adults with a history of DSH rated potential reasons for DSH as being primary, secondary or not relevant. Although affect-regulation and self-punishment were both selected by the majority of participants, affect-regulation was overwhelmingly rated as the primary reason and self-punishment as the secondary reason. Therefore, the seemingly inconsistent pattern of findings within the research literature may in fact reflect the fact that although participants identify with self-

punishment as a reason, fewer consider them to be the primary reason for their DSH

The Sensation-Seeking Model

Within the sensation-seeking functional model, DSH is seen as a means of generating excitement or exhilaration similar to that reported by sky-diving or bungee jumping enthusiasts. This model appears to have received the least attention by researchers, but has been discussed by a few commentators (Shearer, 1994; Osuch et al, 1999). Only modest evidence has been found for a sensation-seeking function for DSH, however, it is important to note that this may be attributed to the dearth of research exploring this particular function. Shearer (1994) found only 5% of a sample of women with borderline personality disorder endorsed this function as one of their top three reasons for DSH. Similarly, Osuch et al's (1999) study, in which six motivations for DSH in psychiatric inpatients were explored, found reasons related to sensation-seeking were the least endorsed.

Evidence of multiple functions of DSH within the literature can be interpreted in several ways which are not necessarily mutually exclusive:

- 1) Differing pathways and functions of DSH may identify different sub-groups of self-harmers
- 2) Multiple functions for DSH may exist within individuals
- 3) The function and pathways to DSH may evolve over time within individuals
- 4) Different 'functional models' of DSH described within the literature may in fact be describing identical phenomena.

TREATMENT OF DSH

Despite DSH being of considerable concern to mental health professionals it has proved difficult to treat (Low et al, 2001) and individuals who self-harm frequently report that services fail to meet their needs (Arnold, 1995; Harris, 2000). Therefore it is critical that research explores patient perceptions of interventions for DSH. Studies have shown that a range of different interventions often lead to improvements in psychological states for those who self-harm, but these interventions typically fail to produce significant reductions in DSH repetition (Hawton et al, 1988; Williams, 1997). Unfortunately, the majority of psychotherapeutic approaches to address DSH which have shown some promise in randomised controlled trials, such as dialectical behaviour therapy and cognitive behaviour therapy (Linehan, 1993; Heard, 2000) require specialist training, often not available to clinical staff working in psychiatric hospitals. More often than not, psychiatric professionals rely on a limited number of pragmatic treatment strategies, often used in combination, gleaned from their own training and experience or from the literature (Huband & Tantam, 2004; Burrow, 1992).

The notion of a 'one size fits all' treatment for individuals who engage in self-harming behaviours is probably unrealistic (Isacsson & Rich, 2001; Hawton & Sinclair, 2003) owing to the heterogeneity of the population. It may prove more useful for researchers to explore which treatment strategies are most effective and which are perceived as most and least helpful by those who engage in DSH, with the possibility of furthering this work by investigating factors modulating perceived helpfulness of treatment. The present study adopted this approach and examined mentally ill men's experience of

DSH-related interventions, closely scrutinising the variables which modulate their perception of the helpfulness of these interventions.

Previous studies concerned with women's perception of helpful treatment for their DSH have indicated the value of face-to-face support, non-punitive responses from others and being able to express feelings and explore underlying causes (Arnold, 1995). Huband & Tantam (2004) explored women's perception of interventions they had experienced in relation to their self-harm. They presented 10 women with 18 pragmatic strategies commonly employed by professionals as interventions for DSH and asked them to rate their opinion of each strategy using a visual analogue scale ranging from -4 to +4. They found that participants ranked having a long-term relationship with one key-worker as the most helpful strategy for managing their self-harm, closely followed by being encouraged to talk about and express feelings about their past. The least helpful strategy was identified as being taught relaxation techniques. The small sample size of ten and the fact that Huband and Tantam's (2004) study focussed on female psychiatric patients raises questions regarding the generalisability of their findings and it is possible that other populations, such as mentally ill men, may have a different perception of helpful and unhelpful professional strategies for self-harm.

GENDER

Gender differences were not specifically explored within this study, rather male self-harm was treated as an issue deserving of research in its own right. The reasons for this will be explored in the following section and will go on to briefly explore gender differences found in relation to DSH.

Male gender is acknowledged as a risk factor for completed suicide (Zahl & Hawton, 2004). However, women tend to present to hospital more frequently than men (Schmidtke et al, 1996) with DSH. Subsequently, some researchers appear to have taken it for granted that women self-harm more frequently than men (Klonsky et al, 2003; Suyemoto, 1998). This appears to have led to researchers exploring self-harm often having an over-representation of women within their sample or excluding men completely from their studies (Gladstone et al, 2004; Shearer, 1997; Himber, 1994; Brown et al, 2002; Soloff et al., 1994; Favazza & Conterio, 1989; Huband & Tantam, 2004; Arnold, 1995). It is important to note that DSH may be just as common in men and this has been found within both clinical and non-clinical populations (Stanley et al, 2001; Gratz, 2001; Klonsky et al, 2003; Briere & Gil, 1998; Soloff et al, 1994). Furthermore, it appears that “grand self-harmers”, individuals who have five or more lifetime episodes of DSH, are more likely to be male (Appleby & Warner, 1993). Such findings indicate a need for research examining male self-harm. The strong research focus on female DSH, has led to an assumption that male self-harm is not particularly prevalent and that the function and treatment needs of men who self-harm are similar to those of women. It is therefore possible that men who self-harm are currently participating in treatment programmes and interventions ill fit to meet their needs.

There is comparatively little literature which focuses exclusively on male self-harm as an issue deserving of research in its own right. Taylor (2003) argued that male DSH is even less acknowledged, accepted and understood than it is in women. Contrary to the impression given by the literature male DSH constitutes a significant problem, which appears to be on the increase, particularly in younger men. Hawton et al (1997a)

explored prevalence rates of DSH over an 11-year period and found a 62.1 % increase in men and a 42.2% increase in women. The largest rise was in the 15-24 year old male sub-group. Favazza (1996) contends that male DSH may be on the increase as men are becoming socialised to be emotionally literate and society is becoming less tolerant of aggression, which is traditionally viewed as seen as a male way of coping with emotional upset (McAllister, 2003).

Studies which explore gender in relation to self-harming behaviours, have found some significant differences which require further focussed attention from researchers. Klonsky et al (2003) reported a stronger association between depression and anxiety in male military recruits who self-harmed than in their female counterparts. In a study of 724 consecutive patients who presented with DSH to a general hospital (Hawton et al, 1997b), alcohol abuse was identified in 10% of men and 7% of women and drug abuse in 12% of men and 6% of women. Hawton et al (1997) described being male and having a history of criminal offences as characteristics more common in substance-misusing individuals who self-harm than in others who self-harm. Thus, substance misuse and a history of criminal behaviour may be more characteristic of men who self-harm, again suggesting a need for direct inquiry into male DSH as distinct from female self-harm.

A Japanese study by Murase et al, (2003) reported that men used more violent means of self-harm (68%) compared to women who were more likely to take an overdose (72%). Likewise, Heila et al (1997) found that younger male subjects often used more lethal methods of DSH. Within the UK, Hawton et al (2004a) studied approximately 15,000 patients who presented, to a general hospital over a 23-year period following an

episode of self-harm. They analysed two distinct periods of time and reported that majority of individuals who used cutting as a means of DSH were in fact male. This may help to explain the finding that men who self-harm are more than twice as likely to die by suicide as women (Hawton et al, 2003b). Gender-based differences in developmental risk factors for DSH have also been found. Gratz et al., (2002) examined the predictive value of several potential risk factors for DSH in a college sample. After controlling for the effect of the other variables they found that sexual abuse was a significant risk factor for DSH among women, but not among men in their sample. Also, parental emotional neglect was not associated with DSH among the male college students; however, it was for their female counterparts. Importantly, childhood separation from parents / caregiver was a significant predictor of DSH among the male students with the majority reporting physical separation from their fathers. Such findings suggesting important gender-based differences in DSH indicate the critical need for further research exploring DSH in men and, in turn, may suggest the need for a gender-specific model of care and treatment is necessary for men who self-harm.

DSH WITHIN PSYCHIATRIC PATIENTS

Much of our knowledge concerning DSH is derived from patient populations (Klonsky et al, 2003). DSH is encountered frequently in psychiatric inpatient and outpatient settings (Favazza, 1989; Suyemoto & MacDonald, 1995). Studies of individuals presenting with DSH to hospital, however, have highlighted that more than 90% of these people have at least one psychiatric disorder (Haw et al, 2001), thus it may be informative to investigate DSH in relation to specific psychiatric subgroups. Graff and Mallin's (1967) seminal paper identified DSH as a mainstream psychiatric problem and

claimed “wrist-slashers have become the new chronic patients in mental hospitals, replacing the schizophrenics” (p.36) and during the early 1980s some were even calling for DSH to become a diagnostic category in its own right (Pattison & Kahan, 1983).

Psychiatric nosology (APA, 2000) identifies DSH as a symptom of borderline personality disorder and it proves to be the most common or arguably, the preferred diagnostic label given to those who repeatedly self-harm (Soloff et al, 1994; Skegg, 2005). Indeed some have even gone so far as to refer to self-harm as the “behavioural speciality” of borderline personality disorder (BPD) (Mack, 1975) as a strong association between this disorder and DSH has been repeatedly demonstrated by researchers (Burrow, 1992; Klonsky et al, 2003; Zlotnick et al 1999; van der Kolk et al, 1991). This association has been sufficiently consistent for many to recommend the use of DSH as a diagnostic marker to distinguish BPD individuals from other disturbed patients (Gunderson & Kolb, 1978; Perry & Klerman, 1980). Consequently, it appears that much of the current evidence-base has focussed on self-harming behaviours specifically within this patient population ignoring other potential diagnoses (Brodsky et al, 1995; Soloff et al, 1994; Shearer, 1997; Brown et al, 2002; Linehan, 1993; Dubo et al., 1997 Low et al, 2001). However, a causal association between DSH and BPD is strongly in question. In many instances DSH may in fact lead to a diagnosis of BPD (Johnstone, 1997; Crowe & Bunclark, 2000). Crowe and Bunclark (2000) argue that a BPD diagnosis is often employed to simply give people who self-harm a diagnosis, even if the person lacks other symptoms of the disorder. Therefore, the seemingly robust association between BPD and DSH may be owing to biased diagnostic procedures.

DSH AND SCHIZOPHRENIA

The present study was concerned with mentally ill men who had received a diagnosis of schizophrenia and had self-harmed, therefore the literature concerned with DSH and suicide among those with this diagnosis will be discussed in the following section.

The majority of studies exploring DSH within schizophrenia have focussed on those who have completed suicide and identifying risk factors for this group. The literature review identified Roy et al (1984) as the only study to have compared schizophrenic patients who had engaged in DSH, but not committed suicide, with those who did not have a history of DSH. Roy et al (1984) examined 127 consecutively recruited patients with schizophrenia who had been admitted to a psychiatric unit between 1974 and 1983. Data was collected from hospital records. Roy et al (1984) found that 55% of schizophrenic inpatients had engaged in DSH with a mean average of 1.8 attempts per patient. Schizophrenic patients who had engaged in DSH had more admissions to psychiatric hospitals and were more likely to have had a depressive episode than patients with schizophrenia who had not self-harmed. A notable limitation of this study was that it focussed on descriptive aspects of DSH and did not explore psychological variables which might distinguish schizophrenic patients who engage in DSH from those who do not.

Suicide and Schizophrenia

Suicide is the major cause of premature death in schizophrenia (De Hert & Peuskens, 2000) and it is estimated that approximately 10% of schizophrenic patients will kill themselves (Meltzer, 1998; Harris & Barraclough, 1997; De Hert & Peuskens, 2000).

This is thought to be 30-40 times higher than suicide in the general population (Caldwell & Gottesman, 1992). Existing studies of DSH in schizophrenia have focussed on socio-demographic and clinical variables and there has been little attention paid to the cognitive and emotional processes underlying this behaviour.

A recent systematic review of 29 studies concerned with risk factors associated with completed suicide in schizophrenia (Hawton et al, 2005) suggested that suicide risk is elevated for men. White people are more at risk than non-white people, although this was based on only three studies. Participants living alone or not living with their families were at greater risk as were those who had experienced a recent loss. Agitation, low self-esteem and hopelessness were all associated with suicide risk. A history of depression and previous DSH episodes independently increased the risk of suicide. Impulsivity was also associated with an elevated risk, although this was based on only two studies. Interestingly, alcohol and drug misuse was not a risk factor for suicide in schizophrenia. As Hawton et al's (2005) systematic review was based solely on selected published papers; it is subject to publication bias. Also some risk factors were studied by a number of researchers, whilst others have been examined by relatively few.

Although there have been a number of studies concerned with the clinical characteristics of schizophrenic patients who engage in DSH, researchers have argued that many of these have been compromised by relatively small sample sizes, problems in diagnostic standardisation, a specific focus on inpatients, the absence of a longitudinal perspective, a limited number of variables and a lack of adequate control group (Heila et al 1997; Caldwell & Gottesman, 1992; Hert & Peuskens, 2000).

Heila et al (1997) conducted a study of the clinical characteristics of suicide victims diagnosed with schizophrenia within the general population of Finland, which appears to have addressed many of the methodological problems of earlier research in the field. They identified 92 individuals with DSM-III-R schizophrenia who had committed suicide from data recording all completed suicides in Finland over a year between 1987 and 1988 and interviewed the victims' next of kin, attending healthcare professionals and the victims' last health or social care contact. Data from psychiatric records and forensic examination results were also explored. Following data gathering, Heila et al (1997) compared male (74%) and female (26%) suicide victims. They found that the mean age of suicide victims with schizophrenia was 40 years with a mean age at first referral to psychiatric care of 24.4 years. There was no significant difference between the sexes on these variables. Women had a higher mean number of admissions to psychiatric hospitals than men. 78% of all the completed suicides within the sample were committed during the active phase of the illness; paranoid schizophrenia was the most common diagnosis for completed suicide (34%); a depressive syndrome was found in 64% of the sample. Alcoholism was present amongst 21% of suicide victims with schizophrenia, but other forms of substance misuse were rare, with only 3 participants fulfilling the criteria for drug abuse. At the time of suicide more than a quarter of the victims with schizophrenia were in receipt of psychiatric inpatient care and more than half had psychiatric outpatient contact. Overdose was the most common suicide method for both sexes; among the 34 overdose victims 79% died following overdose using a prescribed neuroleptic drug. Men tended to use more violent means of suicide compared to women and 69% of male suicide victims within the sample had a previous history of DSH. 10% of men and 4% of women within the sample had a

history of command hallucinations. It is important to note that Heila et al's (1997) use of multiple statistical tests may have led to some spurious observed associations.

Schizophrenia, Depression and Suicide

The presence of depression within schizophrenia is arguably the most frequently identified risk factor for suicide (Gupta et al, 1998; Rossau & Mortensen, 1997; Heila et al, 1997; Drake & Cotton, 1986; Roy 1982). Yet, according to Fenton (2000) screening for depression, hopelessness and suicidal ideation is often ignored and studies often do not explore the precise nature of the relationship between depression and suicide in schizophrenia. In a matched controlled study, Drake and Cotton (1986) addressed this issue and examined the individual clinical features of depression, including hopelessness, and their relationship to major depressive episodes and subsequent suicide in a group of schizophrenic inpatients. They found that a high proportion of patients admitted to hospital with schizophrenia exhibit depressive symptoms; these patients often manifested the full depressive syndrome as defined by DSM III criteria. Prior to suicide, schizophrenic patients frequently appeared depressed, but only a minority experienced a major depressive episode. Instead they were more likely to experience hopelessness. Neither somatic symptoms nor depressed mood alone indicated a high risk of suicide. Drake and Cotton (1986) stated that in the absence of hopelessness, depressed schizophrenic patients are at no greater risk for suicide than non-depressed patients with schizophrenia. There were numerous methodological problems with this study. The sample size was relatively small and only consisted of 15 inpatients who had committed suicide with 89 control schizophrenic patients who did not commit suicide in a 3-7 year follow-up following admission to hospital. A small sample size affects the external validity and

generalisability of the findings. The control group was described as consisting of a large proportion of patients who had a history of DSH (49%), but the analysis did not differ those with a history of DSH and those without in terms of depression and hopelessness. The study used evidence derived from case notes to identify DSM III criteria for depression and to identify hopelessness according to the Beck Hopelessness Scale; neither of these tools was designed to be used retrospectively nor in the absence of the patient and this would affect the internal validity of the study. Identifying criteria for depression and hopelessness was carried out by two independent raters blind to outcome and inter-rater reliability was established in order to enhance reduced subjectivity in rating and this may have gone some way to improving internal validity. In light of such problems with internal and external validity Drake & Cotton's (1986) finding should be treated with some caution.

Symptoms of Schizophrenia and DSH

In a long-term follow-up study, Fenton et al (1997) examined the relationship between diagnostic symptoms and suicidal behaviours among patients with schizophrenia and schizophrenia spectrum disorders. Based on index admission records, patients were retrospectively assessed using the Positive and Negative Syndrome Scale. Completed suicide, suicidal attempts and suicidal ideation during the follow-up period (19 years mean average) were assessed through interviews with patients and / or relatives. 40% of patients reported suicidal ideation, 23% reported suicide attempts and 6.4% had completed suicide. Patients who had completed suicide had a significantly lower negative symptom severity at index admission than those without DSH. Two positive symptoms, suspiciousness and delusions were more severe among successful suicides. A major problem with this particular study is that data from patients with schizophrenia

and schizophrenia spectrum disorders were assessed as a homogenous group and it is possible that differences exist between diagnoses.

Findings concerning suicide risk associated with active positive symptoms of schizophrenia, such as auditory command hallucinations and delusions have been inconsistent (Hawton et al, 2005; Fenton et al, 1997; Grunebaum et al, 2001; Heila et al 1997; Roy, 1982; Cantor et al, 1989). However, some research has suggested that active positive symptoms may play a critical role in episodes of DSH within some schizophrenic patients (Heila et al 1997; Roy, 1982; Fenton et al, 1997) and a small group of schizophrenic patients are believed to engage in DSH in response to positive symptoms of the illness (Simms et al, 2007; Rogers et al, 2002; Heila et al, 1997; Barraclough et al, 1974; Planansky & Johnston, 1973; Falloon & Talbot, 1981; Hellerstein et al, 1987, Roy 1982; Waugh, 1986).

Fialko et al (2006) suggest that there are several reasons to expect hallucinations and delusions as specific risk factors for DSH within the schizophrenic population, including a tendency for irrational thinking and behaviour when positive symptoms are pronounced. Fialko et al (2006) examined suicidal ideation in 290 adults (18-65 years) with psychosis (ICD-10, F20), who completed a number of standardised psychometric assessments. 71% of participants were male and the mean age of all participants was 37.6 years. 39% of the sample had a history of DSH. Auditory hallucinations were found to be related to level of suicidal thinking and the emotional characteristics of the voices were significantly associated with suicidal thinking. Delusions of guilt were found to increase suicidal thinking. It is possible that the use of multiple psychometric assessments within this study may have resulted spurious associations.

Command Hallucinations and DSH

A Singapore study found that 92% of patients who heard voices within their sample complied with command hallucinations to self-harm (Lee et al, 2004). Lee et al (2004) maintained that individuals who repeatedly self-harm are impulsive and such lack of restraint may increase their vulnerability to comply with command hallucinations. Simms et al (2007) studied DSH, beliefs about voices, depression, hopelessness and suicidal ideation. They found that approximately half of those who experienced auditory hallucinations and self-harmed reported that they had self-harmed in direct response to the voices instructing them to do so. These participants also believed their voice to be significantly more malevolent, had a tendency to resist their voice, experienced greater depression, hopelessness and suicidal ideation compared to those that did not hear voices. This mirrors findings that people with schizophrenia and auditory hallucinations experience greater levels hopelessness and are more likely to have a history of DSH (Gallagher et al, 1995; Lee et al, 2004). Hustig and Haffner (1990) found comorbid depression and auditory hallucination in schizophrenia, and that the more ‘intrusive’ and ‘distressing’ the voices the greater the degree of depressive symptomatology. Such findings highlight the need for dedicated research which attempts to elucidate the unique relationship between hearing voices, depression and DSH within this population.

Delusional Beliefs and DSH

Delusional beliefs may also play a significant role within DSH in schizophrenia. Waugh (1986) described a case in which a young psychotic man castrated himself in response to the biblical passage, Matthew 19:12, which states “There are eunuchs born

that way from their mother's womb, there are eunuchs made so by men and there are eunuchs who have made themselves that way for the sake of the Kingdom of Heaven". Waugh (1986) refers to another case report by Kushner (1967) in which a delusional belief stemming from a literal interpretation of this particular biblical passage led to autocastration in two schizophrenic men and cites this as evidence that a group of schizophrenic men may castrate themselves, a form of DSH, as a response to a complex system of delusional beliefs.

DSH WITHIN FORENSIC POPULATIONS

For the purpose of studying of DSH within mentally ill men in a high-secure hospital one can draw upon the body of literature from institutional settings such as prison and secure inpatient hospitals. Findings from studies of DSH within prison and secure inpatient settings will be briefly discussed, with research exploring DSH within high secure hospital settings being considered in more detail.

DSH within Prisons and Secure Inpatient Hospitals

The prevalence of DSH among male prisoners has reported to be much higher than that of the general population (Meltzer et al, 2003) and is estimated to range from 6.5% to almost 25% (Cooper, 1971; Toch, 1975). The reason for these high rates of DSH in forensic settings is unclear. Bach-Y-Rita, (1974) postulated that the isolation and deprivation experienced within prison regimes, removes the individual's coping competencies, thus placing him or her at greater risk of DSH. Teplin's (1990) work highlights the greater prevalence of psychiatric disorder among prisoners as a risk factor for DSH in this group.

Haynes and Marques (1984) studied suicides in a California state prison hospital and found that the mortality rate was four times higher than within the general population. Robertson (1987) reported a moderately elevated risk of violent death, especially, suicide in a sample of convicted male offenders in hospital treatment. A study of mortality among mentally disordered offenders conducted by Bjork & Lindqvist (2005) reported an elevated risk of premature death and, in particular, a risk of suicide. Similar results were found by Pritchard et al (1997) in a sample of men on probation in the UK. In a survey of psychiatric morbidity among prisoners in England and Wales, Singleton et al (1998) found that over a quarter of male remand prisoners had at least one life-time episode of DSH. Similarly, Maden et al (2000) studied 1741 male prisoners found that 17% reported at least one life-time episode of DSH with the majority of these incidents occurring outside of prison. Prisoners who have harmed themselves were much more likely to have experienced a variety of adverse life events, both in the last 6-months and particularly over the course of their life (Meltzer et al, 2003). Typically these adverse events included violence and sexual abuse.

Madden et al (2000) described higher rates of DSH in White male prisoners compared to their Black / Afro-Caribbean counterparts. They also found that prisoners with a history of DSH were more likely to have attracted a diagnosis of a personality disorder (9 times more likely), alcohol abuse (2-4 times more likely) and a neurotic disorder (2-4 times more likely). Likewise, Singleton et al (1998) found higher rates of personality disorder, neurotic disorder and alcohol abuse among prisoners who self-harmed. Importantly, they also found that although psychosis was only found in 5% of their prison sample, the prevalence was substantially increased to between a quarter and half of those who had engaged in DSH over the previous year.

Being charged with murder / manslaughter may be an important risk factor for suicide within forensic populations. Du Rand et al (1995) reported that inmates charged with murder or manslaughter comprised 39% of all suicides within an urban prison in the USA between 1967-1992 and were thus 19 times more likely to commit suicide than inmates charged with other offences. Likewise, in a study of 44 completed suicides and 198 episodes of DSH in the Netherlands, Kerkhof and Bernasco (1990) found that 40% of all suicide victims and 18% of those who self-harmed had been charged with murder / manslaughter compared to only 7% and 4% of controls respectively.

Shea (1993) explored the personality characteristics of 30 male prisoners with a history of DSH and 30 male prisoner controls using a standardised psychometric personality measure. He found that the DSH group reported significantly more somatic concerns, greater subjective distress, immature defences and alienation from others. It is unclear as to whether being alienated from others is a response to or cause of Meltzer et al's (2003) finding that prisoners who engage in DSH often have very small primary support group and a severe lack of social support. Allen (1969) found that when minor DSH failed to meet the individuals' needs, inmates engaged in more severe DSH in an effort to get their needs met.

Jeglic et al (2005) examined the functions of DSH within four individual offenders and found four major functions; suicidal intent, manipulation of the environment, emotion regulation, a response to psychotic delusions or hallucinations. Modelling of DSH within forensic populations has also been documented, with inmates who had no history of DSH engaging in these behaviours as a means of problem-solving (Allen,

1969; Rada & James, 1982). Similarly, a 'contagious' clustering quality to DSH has been described in young people who become aware of peers who self-harm and has been reported as a strong risk factor DSH in a school-based study (Hawton et al, 2002; Gould et al, 1994; Rosen & Walsh, 1989).

White et al (1999) examined DSH in men within a medium secure hospital. Extracting data from 88 case files they found that the overall incidence of DSH was 45.5% and that overdosing and wrist / throat cutting were the most common methods employed. Having an index offence of a non-sexual violence, a history of physical / sexual abuse and a mental illness diagnosis predicted DSH. Another study of DSH within a medium secure hospital found that self-harm was related to the content of command hallucinations (Rogers et al, 2002).

DSH within High-Secure Hospitals

It was estimated that between 1994-1995 the financial cost of DSH within a high secure psychiatric hospital was approximately £227,000, this includes consultant call-out charges, A & E treatment and escort, inpatient treatment and escort, transport to the hospital and X-rays (Swinton & Smith, 1997). As Low et al, (2001) pointed out this is likely to be a gross underestimate of the true fiscal burden of caring for individuals who repeatedly self-harm within a high secure hospital as it does not account for the cost of close nursing observations such as one-to-one staffing nor the cost of psychological intervention. There has been a paucity of research exploring DSH within patients in high secure hospitals, in spite of the knowledge that this group show a much higher incidence rate of DSH compared to the general population (Low et al., 1997; Jackson, 2000). Studies of DSH within high secure hospitals have generally focused on

women or simply explored the frequency and prevalence of male self-harm (Jackson, 2000; Burrow, 1992; Low et al, 1997; Swinton et al, 1998).

Low et al (2000) appears to be the only study of DSH within a high-secure hospital setting that does not strictly focus on prevalence and frequency of episodes. The authors explored the relationship between DSH, childhood trauma and dissociation in female patients at Rampton hospital, excluding male patients, those with a Mental Health Act Classification (MHA, 1983) of Mental Impairment and those with a dual MHA (1983) classification. They separated 50 patients into three subject groups; non-harmers, infrequent harmers (those who had DSH frequency of less than once per month) and frequent harmers (those who had a DSH frequency greater than once per month) and participants completed a number of six psychometric measures exploring self-esteem, irritability, depression and anxiety, hopelessness, dissociative experiences, suicidal ideation, impulsivity and reasons for living. Low et al (2000) found that patients who self-harmed reported higher inward and outward directed irritability, impulsiveness, suicidal ideation along with fewer survival and coping beliefs and lower self-esteem. Frequent harmers scored highest on the dissociation measure. Low et al (2000) also describe dissociation as the mediating link between childhood sexual abuse and DSH. This study has a number of notable limitations. Firstly, the relatively small sample size in addition to the fact that participants were from a female high-secure patient population raises questions regarding the generalisability of these findings to other populations. Secondly, the study employed multiple assessment measures and thus it is possible that some differences may have arisen by chance. Thirdly, the subdivision of participants into groups of self-harmers according to frequency of DSH was based on the previous 30 months rather than lifetime rates.

Burrow (1992) surveyed DSH within a high secure hospital over a 6-month period in 1987 using data gathered via nursing daily ward reports. The sample consisted of 213 men and 90 women. He reported 475 episodes of DSH and found that the vast majority of these recorded incidents (64%) involved female patients and only 17% of incidents involved male patients. Female personality disordered patients had the greatest recorded episodes of DSH across psychiatric diagnoses and represented 53% of the identified DSH patients. The most common method of DSH within Burrow's (1992) sample was head-banging, accounting for 28.6% of total injuries, followed by cutting which made up 26% of injuries. 45.6% of DSH incidents occurred in the general ward area, 24.2% within seclusion or a 'cleared side room', and 23.2% within patients' own room. The number of incidents of DSH within occupational therapy workshops, hospital social occasions and the education centre was negligible. Fewer episodes of DSH occurred at the weekend (16.2%) compared to during the week (58.3%), this may be owing to the more relaxed weekend routine. 25.3% of incidents occurred at night when staffing levels are often reduced to a minimum. Burrow (1992) also found that nursing management of DSH within a high secure hospital consisted of a fairly limited range of interventions such as, prescribed medication, 'cleared room' / seclusion, observation of ward courtyard, continuous 'special observation' at close quarters and restraint garments. Most often these interventions were used in combination, with medication and seclusion often being used concurrently. Burrow's (1992) study was limited by its use of nursing ward reports as a data source as it is possible that not all acts of DSH may have come to the attention of nursing staff and although it describes the frequency and prevalence of DSH within a high secure patient population in some

detail, it does not explore the function or pathway to episodes of DSH within this group from patient accounts of episodes.

The literature review revealed Jackson (2000) as the only study concerned with DSH within mentally ill men in high secure hospital. Jackson (2000) used a retrospective research paradigm in which nursing case notes from one admission, one long-term treatment and two rehabilitation wards were explored over a 30-month period, between 1st August 1995 and 31st Jan 1998. The study aimed to establish the prevalence and frequency of DSH among patients served by the Mental Health Service Directorate (MHSD) at Rampton Hospital and test the hypothesis that male patients in a high security setting who engage in DSH are younger than those who do not. The study also investigated whether there are differences in the frequency of DSH between male patients with a PD or an MI Mental Health Act Classification (1983). Jackson (2000) found that 19% of the 127 patients engaged in DSH during the study period and there were 122 recorded incidents. The most frequently employed method of DSH was cutting, accounting for 25% of incidents, followed by punching / kicking solid objects (21%) and head-banging (19%). Male patients who engaged in DSH were significantly younger than those who did not and there was no difference in the frequency of DSH with PD and those with MI. Jackson's (2000) study has a number of methodological problems similar to that of the Burrow (1992) study. Firstly, the research design was retrospective and used information gathered from case notes from a sample of all of the wards within the MHSD. The author noted that case note information was not available for the long-term treatment ward prior to 11th May 1996 and there was no data for one rehabilitation ward between 4th January 1997 and 3rd July 1997 consequently it is possible that the prevalence and frequency reported is an underestimate of the true

figures. Secondly, inter-rater reliability was not established to reduce potential subjective biases. Lastly, the study is narrowly focused upon the prevalence and frequency of male DSH within a high-secure hospital, ignoring pathways and functions of episodes of DSH.

Surprisingly, despite the dearth of research in DSH in high secure populations, gender differences have been found in terms of patient Mental Health Act (1983) classification and frequency of DSH. Studies have found that the frequency of DSH among women within a high secure hospital was significantly greater among those classified with a psychopathic disorder (Burrow, 1992; Low et al., 1997; Swinton et al., 1998). However, Burrow (1992) and Jackson (2000) independently found no difference in the frequency of DSH in male patients classified with a psychopathic disorder and those with a mental illness. This suggests that male DSH within a high-secure hospital setting may be qualitatively different than their female counter-parts and this is an area in critical need of dedicated research.

Studies exploring DSH within forensic populations have tended to focus on the phenomena within institutional settings, and Madden et al (2000) argued that it is “unreasonable to see the problem only in institutional terms and to ignore an individual’s life prior to imprisonment”. The present study addressed this criticism and explored life-time episodes of DSH in mentally ill men, taking into account factors related to the person’s life prior to admission to a high secure hospital.

SUMMARY AND AIMS

In summary, deliberate self-harm is a major public health concern, and many individuals who self-harm have stated that current services fail to meet their needs. Authors have argued that our present understanding of the development of self-harming behaviours is based on research focussed on women with a diagnosis of borderline personality disorder (Shearer, 1997; Klonsky, 2003; Suyemoto, 1998). It has often been assumed that the aetiology of male self-harm is indistinguishable from that of their female counterparts. However, recent research findings appear to suggest potentially important gender differences (Gratz et al, 2002; Murase et al, 2003). Furthermore, it has been found that male self-harm is on the increase and that those with a diagnosis of schizophrenia are particularly at risk (De Hert & Peuskens, 2000; Caldwell & Gottesman, 1992; Meltzer et al, 2002a), as are those within a high secure hospital (Burrow, 1992; Jackson, 2000). No study as yet has explored the pathways to episodes of self-harm for mentally ill men detained in a high secure environment and their treatment needs. Dedicated research focussed on the development and function of DSH for this group is essential and is likely have major implications for the care and treatment of mentally ill men who self-harm in other settings.

The primary aim of this research was to explore the causal pathway(s) experienced by a small sample of mentally ill men detained within a high secure and to explore their perception of interventions for self-harm using Grounded Theory methodology, with a secondary aim of developing a conceptual overview of the development and function of this phenomena within this often ignored population.

In addition to the research questions posed within the article, the study addressed two further research questions:

(1) What causal pathway to deliberate self-harm did mentally ill men in a high secure hospital experience during their first episodes?

(2) What are these men's views of interventions in relation to their self-harm?

It was anticipated that this study would contribute to and extend knowledge of the development of male self-harm and factors associated with helpful and unhelpful interventions for this group. It may highlight areas of current good practice and areas in need of improvement in the care and treatment of men who self-harm within high secure hospitals. It may help to identify those at risk of repeated DSH. The study may also lead to the development of evidence-based treatment programmes which are developed with the needs of men who self-harm in mind and subsequently lead to improved patient outcomes.

APPENDIX C

EXTENDED METHODOLOGY

The present study adopts a qualitative Grounded Theory approach to address the aforementioned research questions. Qualitative research is concerned with understanding lived experience and how participants make sense of their experiences. Therefore, it is concerned with the meanings which experiences hold for the participants. The present study is qualitative in that it seeks to explore individuals' experiences of episodes of DSH as opposed to attempting to produce a record of the event or state itself.

Grounded Theory is a research method developed by Glaser and Strauss (1967). It is a general methodology for developing theory that is grounded in the research data which is systematically gathered and analysed (Strauss & Corbin 1994). The data-driven theory develops throughout the research process due to the interplay between data collection and analysis phases. The end result of a Grounded Theory study is the generation of a theory, consisting of a set of plausible relationships proposed among themes and sets of themes. These sets of themes are referred to as core categories (Strauss & Corbin, 1990) within this study.

Within a Grounded Theory study the researcher is thought to maintain an objective stance throughout by comparing data sets (Strauss & Corbin, 1990 p.43); by asking themselves "What is going on here?" and "Does what I think I see fit the reality of the data?" (Strauss & Corbin, 1990 p.45) and sampling based on evolving theoretical concepts (Strauss & Corbin, 1990 p.46).

The Grounded Theory approach to scientific inquiry has been gaining increasing attention within research in recent decades, as it has a number of advantages over other qualitative methods of inquiry. For example, Grounded Theory represents an integrated and systematic method of participant recruitment, data collection and analysis. Other qualitative methods often rely upon the application of general principles rather than a systematic method and this can lead to their application and interpretation proving more difficult to replicate.

Grounded Theory was selected as the most appropriate approach to address the aims and research questions as the approach has been highlighted as particularly useful in situations where little is known about the subject matter under investigation (Sarantakos, 2005). Furthermore, the study sought to explore individual experiences of episodes of DSH in an effort to develop a theory regarding pathways to self-harm experienced by mentally ill men within a high secure hospital and the end product of a grounded theory study is theory generation (Strauss & Corbin, 1990). The qualitative exploratory nature of the study accomplished a deeper and richer understanding of the issue of male self-harm than would be achieved through quantitative research methodologies. Moreover, it highlights useful avenues for further research within the field.

Sample:

Participants were recruited from the Mental Health Services Directorate (MHSD) within Rampton Hospital, a high secure psychiatric hospital within the UK. The adult patients served by the MHSD are male and are currently detained under the Mental Health Act (1983) with a primary legal classification of a Mental Illness. The patients

reside on admission, long-term treatment, and rehabilitation wards or the intensive mental health care ward.

Participant Inclusion Criteria:

- Male
- Aged 18+
- Currently detained within a high secure psychiatric hospital under the Mental Health Act (1983)
- Legal Classification of Mental Illness and / or Psychopathic Disorder
- Experience of two or more life-time episodes of DSH – as identified by the RMO or member of the psychology department

Participant Exclusion Criteria:

- Legal classification of Mental Impairment – as it would have been difficult to ensure informed consent.
- Significant hearing or vision problems that is not rectified by glasses or a hearing aid – as this was thought to compromise obtaining informed consent and the findings of the study.
- Unable to read or speak English or have special communication needs – as this may compromise obtaining informed consent to participate and the use of an interpreter may compromise the validity of the derived data.

- Currently participating within psychological treatment addressing their DSH – as this may compromise therapeutic progress.

Procedure for Recruiting and Obtaining Informed Consent:

The study adopted the following approach in order to identify and recruit eligible participants:

The researcher approached consultant psychiatrists within the MHSD at Rampton Hospital asking permission to approach patients on their caseload regarding participating in the study. The researcher then approached members of the psychology department and consultant psychiatrists based within the MHSD at Rampton by letter, asking them to help identify and approach potentially eligible participants. These members of staff were given the ‘Information Sheet for Staff’ for their own information in addition to copies of the ‘Participant Information Sheet’ and the ‘Consent Form’ to give to eligible participants.

By completing the Consent Form, participants agreed to take part in the interview and give the researcher consent to contact their RMO (Responsible Medical Officer) to seek clarification of their eligibility to take part in the study, advice regarding whether the interview was likely to adversely affect their mental health in the RMO’s clinical opinion.

The potential participant sent the signed consent form to the researcher via members of their clinical team or the hospital internal mail system. For participants who gave their

consent at this stage, the researcher contacted their RMO by letter or telephone. If participation in the study was likely to have a negative impact upon the participants' mental health or they did not confer to the eligibility criteria, the researcher informed the individual of this in writing and did not pursue further contact. Those identified as eligible, in the manner described above, were contacted by the researcher who described the study in greater detail, discussed the information on the 'Participant Information Sheet' and the 'Consent Form' and answered any questions that participants had regarding their participation.. Following this, a mutually agreed date and time was arranged for interviews. Participants had a minimum of one week in which they could decide to take part in the study and did not receive payment for their participation.

Following the above recruitment procedure, the researcher met with those who had indicated willingness to participate in the study and interview. Only when the above steps have been completed did the interview commence. Each participant was given a copy of the consent form and Participant Information Sheet to retain. Owing to the method of recruitment to the study, it was not possible to identify the number of participants who were approached and refused to participate.

Theoretical Sampling Procedure and Sample Size:

The study employed a theoretical sampling technique in which individuals who were likely to provide the greatest insight into the research questions were approached to participate. Theoretical sampling aimed to maximise the study's opportunity to discover variations among emerging concepts and increase theoretical understanding of categories in terms of their property and dimensions by asking specific questions

related to the emerging themes, core categories and theory. Although Strauss and Corbin (1990) suggest that theoretical sampling should continue until the study reaches a theoretical saturation point, the present study was unable to achieve this as only seven participants indicated willingness to participate. Therefore, participants were consecutively recruited to the study until no further willing / eligible participants came forward. The final sample size of seven participants is congruent with other qualitative studies of a similar nature (e.g. Jeglic et al, 2005; Huband & Tantam, 2004), where sample sizes tend to be small owing to the large volume of verbal data to be analysed.

DATA COLLECTION:

Participants took part in a semi-structured interview with the researcher, which lasted between 45 minutes and 2.5 hours approximately. The interview was audio-taped to facilitate transcription and took place in a quiet private room on the ward the participant resided on.

The semi-structured interview schedule was designed to collect data at three global levels to address the aims and research questions (see Table 3):

- 1) DSH Descriptive Level
- 2) DSH Aetiology Level
- 3) DSH Intervention Level.

Table 3 - Levels of data collected

Global Level	Specific data collected
DSH Descriptive	Number of life-time episodes of DSH Frequency of DSH Methods of DSH used and typical method Length of time since last episode Age at first episode of DSH
DSH Aetiology	Subjective experience of first episode of DSH, with specific prompts for triggers, physiological changes, emotions, and thoughts associated pre and post. Last or typical experience of DSH, with specific prompts for situations, physiological changes, emotions, and thoughts associated pre and post. Subjective view of developmental factors which may have influenced DSH
DSH Intervention	Views and experience of professional intervention with respect to DSH, with specific prompts for factors associated with participants' perception of helpful and unhelpful interventions.

The semi-structured interview enabled a token level of focus to the study and allowed the participants to provide a fuller, richer account than would be possible with a standard quantitative instrument. Furthermore, the semi-structured interview format allowed considerable flexibility in probing interesting issues which emerged in a significantly under-researched area. During the course of the interview, the researcher frequently reflected back to the participant what has been said in an attempt to enhance the trustworthiness of the collected data. Participant case files were reviewed for demographic information following the interview to minimise researcher bias owing to prior knowledge of participants' history during the interview and to reduce the length of time of the interviews. The following demographic information was collected:

- Age
- Ethnic / cultural background
- Diagnosis

- MHA (1983) Classification
- MHA (1983) Section
- Index offence
- Number of life time episodes of DSH
- Methods of DSH
- Age at first attempt of DSH
- Method at first attempt of DSH
- Length of time since last episode of DSH
- Frequency of DSH

ANALYSIS:

In line with grounded theory methodology (Strauss & Corbin, 1990), the audio-taped interview was transcribed as soon as possible after the interview to enable the researcher to analyse and identify emergent themes. These emergent themes subsequently served as guide for additional questions in further interviews. The design of the semi-structured interview allowed for first and typical episodes of DSH and participants' views regarding DSH-related interventions to be analysed separately. The written transcriptions were analysed and coded following the Grounded Theory and constant comparison methodology proposed by Strauss and Glasser (1967). Initially interview data was compared to other interview data. Through the process of coding and memoing a theory began to evolve that was grounded in the data. Once this theory began to emerge, it was then compared to further data to validate or disconfirm the theory as it stood. The emerging theory had to be able to account for new data.

Coding and Memoing:

Coding involved three distinctive phases, Open Coding, Axial Coding and Selective Coding (Strauss & Corbin, 1990).

The Open Coding phase involved the close scrutiny of words, sentences and phrases within the data to identify codes and concepts, which can be thought of as ‘themes’ or variables that makes sense of what the participant had said. In order to identify themes, the researcher asked “What is the major idea brought out in this sentence or paragraph?” The identified themes were written into the margin of individual transcripts and made use of *in vivo codes* drawn directly from the participants’ own words (Strauss, 1987, p.33). Open Coding allowed similar themes to be compared and contrasted, both within individual interviews and between interviews. Themes of a similar nature were combined.

Within the Axial Coding phase, causal relationships between themes were identified. These relationships were cause, interaction or consequence effects. The aim within this phase was to make explicit connections between themes based upon the data in order to understand the phenomena. At this stage a theory began to emerge and core categories could be identified. The axial coding process allowed for the identification of core categories which were comprised of themes which explained the properties and dimensions of the core category.

Selective Coding involved identifying themes and core categories which had been endorsed by two or more participants and systematically relating them to other themes

and core categories endorsed by these participants. This was achieved by exploring the memos created throughout the analysis. Selective coding also involved validating and refining the relationships between themes and core categories (Strauss & Corbin, 1990). These relationships were then integrated to form a theory regarding pathways specific typical episodes of DSH in this population. This theory was then compared and contrasted with further data to validate or disconfirm the emergent theory.

Strauss and Corbin (1990) emphasise the importance of memo-writing in ensuring the researcher remains grounded in the data. Memoing occurred throughout the analysis process and involved theoretical note making in which the researcher developed hypotheses regarding themes in terms of their properties, dimensions and relationship with other themes. The researcher also made memos regarding the formation of core categories and how these may be related. The memoing process allowed for theory development and aided the diagrammatic conceptualisation of the emergent theory.

Trustworthiness of the Study:

It is particularly important for a qualitative study of this nature to be able to demonstrate the trustworthiness of the results (Henwood & Pidgeon, 1993). The present study addressed this issue at several levels.

Consistency within the Interviews:

Practical constraints such as restrictions on patient movement within Rampton Hospital resulted in participants being interviewed on different wards and rehabilitation villas and this may impact upon the findings. The researcher strived to ensure that interview settings were as similar as possible and there were no major differences in the

interview setting. It was possible that researcher characteristics could influence the participants' responses. This was controlled for, by ensuring that the same researcher conducted all of the interviews to ensure consistency. Additionally, the findings were fed-back to participants to confirm or disconfirm the accuracy of the proposed theories.

Semi-Structured Interview Schedule Design:

The semi-structured interview questions were designed to be free of double negatives or complex jargon and did not contain leading questions nor make assumptions which may lead to biased results. Interview questions were ordered appropriately and sensibly related to avoid confusion and made use linking explanations between questions. In order to overcome potential difficulties associated with the semi-structured interview, the schedule was piloted on two assistant psychologists based within the MHSD at Rampton Hospital and appropriate amendments made based upon their feedback and knowledge of the sample population and then re-tested on two different assistant psychologists. Piloting involved establishing whether individuals understood the aims and purpose of the interview and identifying questions which were ambiguous or used complex terminology as this may have affected participant comprehension. Feedback regarding the length of time taken to complete the interview was also sought.

Trustworthiness of Data and Analysis:

Socially desirable responding may also be an issue; with participants trying to give "the right answer". In order to address this, participants were assured that there were no right or wrong answers and that the study was concerned with their experiences. Information elicited was reflected back to the participants throughout the interviews, to confirm or disconfirm the researcher's understanding. All interviews were audio-taped

to facilitate transcription. This enhanced the trustworthiness of the study as it allowed for repeated examination of the data and opened up the data to scrutiny by other researchers. Participant case files were reviewed to collect demographic information after the interview. The researcher read through the final article write-up with participants in order to give them the opportunity to comment upon the findings, verify whether it reflected their experience and answer any questions participants had regarding the findings and study. The results write up contains a number of quotations from the participants' accounts thereby providing readers with the opportunity to form their own opinions regarding the validity of the derived concepts, categories and theory.

APPENDIX D

NOTTINGHAMSHIRE RESEARCH ETHICS COMMITTEE 2 ETHICAL APPROVAL LETTER

1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 0115 912 3344 ext 49435
Facsimile: 0115 9123300

02 November 2006

Miss V Multra
Trainee Clinical Psychologist
University of Lincoln
Department of Psychology
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Multra

Full title of study: **Accounts of repeated self-harming and attempted suicide among mentally ill men detained in a high secure hospital: An exploratory study.**

REC reference number: **06/Q2404/126**

Thank you for your letter of 13 October 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	1	08 September 2006
Investigator CV: Educational Supervisor	1	01 January 2006
Investigator CV: Chief Investigator	1	01 April 2006
Protocol	3	01 October 2006
Letter from Sponsor		08 September 2006
Peer Review		
Peer Review		24 August 2006
Interview Schedules/Topic Guides	1	01 August 2006
Participant Information Sheet: Patient	1	01 August 2006
Participant Information Sheet: Staff	2	01 October 2006
Participant Consent Form	3	01 October 2006
Response to Request for Further Information		13 October 2006
RMO Letter	2	01 September 2006

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

With the Committee's best wishes for the success of this project

Yours sincerely

Dr M Hewitt / Ms L Ellis
Chair / Committee Coordinator

Email: linda.ellis@rushcliffe-pct.nhs.uk

APPENDIX E

NOTTINGHAMSHIRE HEALTHCARE R&D APPROVAL LETTER

E-mail: shirley.mitchell@nottshc.nhs.uk

Research & Development
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

Tel: 0115 969 1300

Fax: 0115 993 4549

Our Ref: FOR/13/11/06

13th November 2006

Miss Vidyah Multra
Trainee Clinical Psychologist
University of Lincoln
Department of Psychology
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Multra,

Accounts of repeated self-harming and attempted suicide among mentally ill men detained in a high-secure hospital: an exploratory study.

I am writing to confirm that the above study is authorised to take place within our Trust.

This is a very interesting and important field of study. The Trust R&D Department follows up such work to assess its impact and influence on practice and policy. All research registered with the R&D Department is automatically included in the National Research Register (www.update-software.com/national) and information on all projects is updated quarterly. Therefore, I have enclosed the National Research Register Information Sheet for your completion.

Please note that you cannot commence your research without a Trust honorary contract in place.

Yours sincerely

Shirley Mitchell
Research Governance Lead & Business Manager

APPENDIX F

INFORMATION SHEET FOR STAFF

Title: Self-harm and suicide among mentally ill men in a high secure hospital

Investigator: Vidyah Multra

AIMS AND BACKGROUND TO THE STUDY

The aim of this qualitative study is to explore the causal pathway to episodes of self-harm and suicide experienced by a small sample of mentally ill men detained within a high secure hospital and their perception of related interventions using Grounded Theory methodology.

It has been argued that our present understanding of the development of self-harming and suicidal behaviours is derived from research focussed on women with a diagnosis of borderline personality disorder (Gratz, 2002; Taylor 2003). Consequently, there has been an assumption that male self-harm is not particularly prevalent and the function and treatment needs of men who self-harm are similar to those of women. However, recent research findings appear to suggest potentially important gender differences (Gratz, 2002)

Contrary to the impression given by the literature male DSH constitutes a significant problem, which appears to be on the increase, particularly in younger men (Hawton et al, 1997). In a survey of the British population (Melzer et al, 2002a) individuals with active symptoms of a mental illness were found to be twenty times more likely to report past self-harm /suicide attempts than those without mental health problems. Furthermore, people diagnosed with schizophrenia were most at risk of repetition and approximately half of this group had self-harmed or attempted suicide at some point during their lives. This finding strongly indicates the need for research to explore the behaviours in those with mental health problems, particularly schizophrenia.

There has been relatively little research exploring self-harming and suicidal behaviours among patients in high secure hospitals, in spite of the knowledge that this group show a much higher incidence rate of these behaviours compared to the general population (Low et al., 1997; Jackson, 2000). Studies of this nature within high secure hospitals have generally focused on women or simply explored the frequency and prevalence of male self-harm (Jackson, 2000; Burrow, 1992). Jackson (2000) found that 19% of the 127 male patients within the Mental Health Service Directorate who engaged in self-harming behaviours over a 30-month period consisted of men younger than 35 years.

Surprisingly, despite the dearth of research of these behaviours among high secure populations, gender differences have been found in terms of patient Mental Health Act (1983) classification and frequency of self-harm. Studies have found that the frequency of self-harm among women within a high secure hospital was significantly greater among those classified with a psychopathic disorder (Burrow, 1992; Low et al., 1997). However, Burrow (1992) and Jackson (2000) independently found no difference in the

frequency of self-harm in male patients classified with a psychopathic disorder and those with a mental illness.

No study as yet has explored the pathways to episodes of self-harm or attempted suicide for mentally ill men detained within a high secure environment and their treatment needs. Dedicated research focussed on the development and function of these behaviours for this group is essential and is likely have major implications for the care and treatment of mentally ill men who self-harm in other settings.

RECRUITMENT TO THE STUDY

In the first instance, the researcher will ask permission from consultant psychiatrists to approach patients on their caseload regarding participating in the study.

Consultant psychiatrists and members of the psychology department are then kindly asked to help identify patients within the Mental Health Directorate who have a history of two or more life-time episodes of self-harm and / or attempted suicide and pass on the Participant Information Sheet to potential participants. Participants who would like to take part are asked to complete the Consent Form and send this to Vidyah Multra based in the psychology department within the MHSD.

The researcher will contact participants identified in the manner described above. The researcher will discuss the information on the Participant Information Sheet and the Consent Form with the potential participant and answer any questions raised. A date and time for the interview will be arranged at this point. Participants will have a minimum of one week in which they can decide to take part in the study and will not receive payment for their participation.

By completing the Consent Form, participants are agreeing to take part in the interview and give the researcher consent to contact their RMO (Responsible Medical Officer) to seek clarification of their eligibility to take part in the study, advice regarding whether the interview is likely to adversely affect their mental health. If participation in the study is likely to have a negative impact upon the participants' mental health or they do not confer to the eligibility criteria, the researcher will inform the individual of this in writing and not pursue further contact.

Prior to the interview the researcher will again discuss the information contained within the Participant Information Sheet and the participant will be asked to sign two copies of the consent forms. They will be given a copy to retain.

A maximum of 15 participants will take part in the study.

WHAT DOES THE STUDY INVOLVE?

Participants are invited to an individual interview with the researcher which will last approximately an hour. The interview will be audio-taped. The interview will occur in a private interview room on the ward or villa the participant resides on.

Participants will be asked to describe episodes of self-harm or suicide attempts and their experience of related interventions. There are no right or wrong answers the study is concerned with participant views and experience.

The researcher will meet up with the individual again to discuss the findings of the study.

HANDLING PATIENT QUESTIONS ABOUT THE INTERVIEWS

We would appreciate your involvement as the likely first port of call for many participant questions.

If a patient approaches you with questions about the study or interview, you can use the enclosed Participant Information Sheet to help explain the process. If you feel unable to answer their questions from this information, please contact the researcher whose details appear on the last page.

There are some important points you may like to emphasise:

Confidentiality: It is important that participants understand that anything they say will be kept confidential, unless there is a risk of harm to themselves or another. The interview will take place in a private room on the ward / villa so that the participant can speak openly and honestly without being overheard. Members of their clinical team will not be present at the interview and will not see copies of the interview notes nor hear the recorded interview. The end report will not include the person's name or any other identifier. Information that could lead to their identification will not leave the hospital.

Impact on care received: Participants should be reassured that, whether or not they decide to take part in the study, neither their legal rights nor the care they receive from Rampton Hospital will be affected. They will not be discriminated against if they decide to take part, or if they decide not to take part.

Right to withdraw: Participants who agree to take part may withdraw from the interview or study at any stage, should they change their mind. They do not need to give a reason for doing so and, again, this will not affect the care they receive.

IF A PATIENT WOULD LIKE TO TAKE PART

Participants who would like to take part are asked to fill in their details on the last page of the Participant Information Sheet and send this to Vidyah Multra based in the psychology department within the MHSD.

The researcher will contact participants to discuss the study in more detail and answer any questions they may have. They will also be asked to sign a consent form, which gives the researcher permission to contact their RMO to discuss the impact of participation on their mental health.

RESEARCHER CONTACT DETAILS

Should you have any questions regarding any of the above or if you feel unable to answer participant questions, please contact:

Vidyah Multra

University of Lincoln
Faculty of Health, Life & Social Sciences
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Lincoln
LN6 7TS
01522 886029

Professor Nadina Lincoln

Institute of Work Health and Organisations
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Nottingham
NG7 2RQ
0115 846 6642

APPENDIX G

PARTICIPANT INFORMATION SHEET

Title: Self-harm and suicide among mentally ill men in a high secure hospital

Investigator: Vidyah Multra

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. You may wish to discuss it with other people. Please ask if there is anything that is not clear or you would like more information. Take time to decide whether you would like to take part or not.

What is the purpose of the study?

The number of men who self-harm or attempt suicide is increasing and we know that people who have mental health problems are particularly at risk. Most of the research so far has focused on women and there has been little research looking at men. Therefore, men who self-harm or attempt suicide might be taking part in treatment that is not helpful for them.

This study looks at the reasons behind why men in a high secure hospital may have self-harmed or attempted suicide over the course of their life. We would like to hear your views about what may have led you to self-harm or attempt suicide and comment on helpful and unhelpful treatment you may have had. There are no right or wrong answers we are just interested in your views and experience.

We are asking for your views to help us get a better understanding of what might lead men to self-harm or attempt suicide and improve the quality of care and treatment they get from professionals. We hope you are willing to help with this work.

Why have I been chosen?

Consultant psychiatrists and members of the psychology department were asked to pass on information about taking part the study to any patient within the Mental Health Directorate who had self-harmed and / or attempted suicide more than once.

There will be a maximum of 15 men taking part in the study.

What will I have to do?

If you are interested in taking part, fill in your details on the last page of this information sheet and send it to Vidyah Multra (Psychology Department – Rampton Hospital).

The researcher will then contact you to talk about the study and answer any questions you may have. You will also be asked to sign a consent form and the researcher will check to see that your psychiatrist thinks it is ok for you to take part.

You will then be invited to an individual interview with the researcher which will last about an hour. The interview will be audio-taped. The interview will take place in a private interview room on your ward or villa so you can speak openly and honestly.

The researcher will meet up with you again to talk about the findings of the study and give you the opportunity to say whether you feel the findings are similar to your experiences or not.

Do I have to take part?

No. You don't have to take part if you don't want to. But it would be very helpful for to hear your experiences. If you do decide to take part but later change your mind, you can withdraw from the interview and study at any time without having to give a reason. Whatever you decide, it will not affect the treatment you receive or your legal rights.

What are the possible disadvantages and risks of participating?

There are no known risks associated with this study.

Self-harm and attempted suicide are sensitive subjects. If the interviewer thinks that the interview is having a negative effect on your mental health, she will stop the interview and ask you if she can tell someone from your care team. At the end of the interview the researcher will ask you if the interview has brought back any memories or feelings that you are finding difficult to cope with. If this is the case, the researcher will ask you if she can inform a member of your clinical team.

What are the possible advantages of participating?

The study will hopefully give us a better understanding of why men have self-harmed or attempted suicide and how professionals can improve treatment.

What if I have a complaint about how I have been treated as part of the study?

If you wish to complain about any aspect of how you have been approached or treated during the course of this study, you can do so through the normal National Health Service complaints procedures.

Will the information I give be confidential?

Yes. The information you give will be treated in strict confidence, unless there is a risk of harm to yourself or someone else as is standard practice. The researcher may inspect your case file to gather background information. Any information about you / that you give which leaves the hospital will have all details which could identify you removed, so that you cannot be recognised.

What will happen to the results of the study?

The results of the study will be submitted as a thesis for a doctorate in clinical psychology. The findings may be published in a scientific journal and may also be

presented at professional conferences. No individuals will be named in the report. If you like, you can ask to be sent a copy of the report when it is published.

What do I do now?

If you would like to take part or find out more about this study, please fill in your details on the 'Consent Form' and send it to Vidyah Multra (Psychology Department – Rampton Hospital). The researcher, who will contact your Responsible Medical Officer (RMO) to find out if taking part in the study is likely to have a negative effect on your mental health.

If you are able to take part the researcher will contact you to discuss the study in more detail, ask you to sign a consent form and arrange a date and time for the interview.

Thank you for your time.

Researcher Details:

Vidyah Multra

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Faculty of Health, Life & Social Sciences
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01522 886029

Dr Louise Braham

Psychology Department
MHSD Rampton Hospital
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Dr Neil Coulson

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APPENDIX H

PARTICIPANT CONSENT FORM

Title: Self-harm and suicide among mentally ill men in a high secure hospital

Investigator: Vidyah Multra

You are invited to take part in an audio-taped interview that is part of a research study looking at the reasons why men in a high secure hospital may have self-harmed or attempted suicide over the course of their life. We would like to hear your views about what may have led you to self-harming or attempting suicide and comment on helpful and unhelpful treatment you may have had.

- Please take time to carefully read the Participant Information Sheet you have been given and ask any questions you feel you need to.
- If you would like to take part in the interview, please sign two copies of this consent form. Please keep one copy for yourself and hand the other copy to the researcher.

Please initial each box and sign at the bottom

1. I confirm that I have read and understood the information sheet about the project “Self-harm and suicide among mentally ill men in a high secure hospital” and have had the opportunity to ask questions which have been answered to my satisfaction.
2. I agree to the researcher contacting my RMO for information about whether I fulfil the criteria to take part in the study and whether the interview will affect my mental health
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my care or legal rights being affected.
4. I am willing to take part in the audiotaped interview and study.

Name of participant

Signature

Date

Name of person taking consent

Signature

Date

Name of witness

Signature

Date

APPENDIX I

SEMI-STRUCTURED INTERVIEW SCHEDULE

For the purpose of this interview, I will use the term “self-harm” to describe any occasion in which you have purposefully hurt yourself whether you intended to commit suicide or not.

DESCRIPTIVE INFORMATION

We know that people self-harm or attempt suicide for many different reasons and in many different ways.

1. How many times would you say you have self-harmed in your life?
2. How often do you self-harm?
3. How have you self-harmed in the past eg. Overdosing, cutting etc.
4. How would you say you typically self-harmed?
5. When was the last time you self-harmed?

LEAD-UP TO FIRST EPISODE

Triggers

1. How old were you the first time you self-harmed?
2. Can you describe what your life was like at that time?
3. How would you describe your relationship with your family and friends at that time?
 - Were there any particular people you did not get on with?
4. Were you experiencing any physical or mental health problems at the time?
 - What were they?
 - Do you think this influenced your self-harming?
 - Were you taking any medication?
5. Were you drinking or taking drugs during that time in your life?
6. Had you been drinking or taking drugs just before you self-harmed for the first time?
7. What happened in the lead up to you self-harming?
 - How long was this lead up?

Emotions

1. Describe how were you feeling emotionally in the days/weeks/months leading up to you self-harming?
2. How were you feeling emotionally just before you self-harmed?

Cognitions

1. Can you remember anything significant that made you think about self-harming?
 - Had you thought about self-harming before?
2. How long did it take to make the decision to self-harm?
3. Did you plan to self-harm or was it more on the spur of the moment?
4. How much planning did you put into self-harming? (Please give example)
5. Did you discuss what you were going to do with anyone else?
6. What were you thinking or telling yourself just before you did it?
7. What were you hoping self-harming would achieve?
8. Did you want to die?
 - Did you think you were going to die?
9. How much did you think about what it might be like to self-harm before you did it?
10. Did you imagine how others might respond to you self-harming?
 - How did you think they would respond?
11. Did you have any second thoughts about doing it?

Arousal

1. Did you notice any changes in your body beforehand eg racing heart, shortness of breath, sweating, butterflies in stomach

BEHAVIOUR DURING FIRST EPISODE

Behaviour

1. What exactly did you do?
2. Where were you?
3. Were you on your own when you self-harmed?
4. Did you have to lie to be able to self-harm?
5. How long were you self-harming for?
6. What brought your self-harming to an end?

Emotions

1. Describe how you felt emotionally as you self-harmed? Eg. excited, nervous, calm, angry, happy, vengeful, emotionless
2. How did these feelings change as you self-harmed?

Physical condition

1. Could you feel any effects of drink, drugs or medication as you were self-harming?

Cognitions

1. What exactly were you thinking or telling yourself as you self-harmed?
2. Did you notice your thoughts changing as you self-harmed?
3. Did you have any doubts or regrets as you self-harmed?

CONSEQUENCES OF FIRST EPISODE

Behaviour

1. What exactly happened after you had self-harmed?
 - What did you do?
 - What did other people do?

2. Did you take any drugs or drink after you self-harmed?
3. Did you receive any medical attention for your self-harm?

Arousal

1. Did you notice any changes in your body? eg racing heart, shortness of breath, butterflies in the tummy etc

Emotions

1. Describe how you felt emotionally after self-harming?
2. Has how you feel about self-harming at that time changed? How?

Cognitions

1. What were you thinking or telling yourself after you self-harmed?
2. Looking back, do you have any regrets about self-harming at that time?

Relationships

1. What did other people (friends / family) think about what you did?
2. How did your self-harming affect your relationship with family and friends?
 - How did that impact on your self-harming?

LEAD-UP TO TYPICAL EPISODES

I am going to ask you some questions about your self-harm or suicide attempts in general

Triggers

1. When you have felt like self-harming is it a slow build up of things or is it one thing that will set you off? (Ask for example)
2. Have you ever had an urge to self-harm?
 - How often do you have these?
 - Are you able to control these urges – how?

3. What is usually happening in your life when you self-harm?
4. Have you usually been drinking or taking drugs beforehand?
5. In the lead up to you self-harming, how would you describe your relationship with other people like friends and family?
6. Do you experience any mental health problems before you self-harm?
 - What are they?
 - Are your mental health problems and self-harm related? – How?
7. Is there anything in particular that makes you think of self-harming?
8. What has usually happened in the period leading up to you self-harming?

Emotions

1. Describe how you are feeling emotionally in the days/weeks/months leading up to you self-harming?
2. How do you feel emotionally just before you self-harmed?

Cognitions

1. When the thought of self-harming comes into your mind, how long does it last? (seconds / minutes / hours). - Are you able to control these thoughts?
2. How long does it take to make the decision to self-harm?
3. Do you plan to self-harm or is it more on the spur of the moment?
4. How much planning do you put into self-harming? (Please give example)
5. Do you discuss what you are going to do with anyone else?
6. What are you usually thinking in the lead up to self-harming?
7. What were you hoping self-harming will achieve?
8. Do you hope that you will die when you self-harm?
9. Do you imagine how others will respond to your self-harming?
10. Do you ever have any second thoughts about doing it?

Arousal

1. Do you notice any changes in your body beforehand eg butterflies in the tummy, sweating, heart racing, shortness of breath etc?

BEHAVIOUR DURING LAST / TYPICAL EPISODE

Behaviour

1. Have you ever had to lie to others to be able to self-harm?
2. How do you usually self-harm - what exactly do you do? e.g. cut, overdose etc
3. Are you usually on your own when you self-harmed? Where are you?
4. What usually brings an episode of self-harm to an end?

Emotions

1. Describe how are you feeling whilst you were self-harming?
2. Do these feelings change as you self-harm? How?

Physical condition

1. Can you usually feel the effects of drink, drugs or medication as you self-harm?

Cognitions

1. What kinds of things are you thinking or telling yourself as you self-harm?
2. Do your thoughts change as you self-harm? How?
3. Do you ever have any doubts or regrets as you self-harm?

CONSEQUENCES OF LAST / TYPICAL EPISODE

Behaviour

1. What exactly happens after you have self-harmed?
 - What do you do?

- What do other people do?
2. Do you take any drugs or drink after you self-harmed?
 3. Do you receive any medical attention for your self-harm?

Emotions

1. Describe how self-harming makes you feel? (elated / unhappy / depressed / frightened / anxious / angry)
2. How did you feel emotionally immediately after self-harming?

Cognitions

1. What kinds of things are you usually thinking or telling yourself after you have self-harmed?

Arousal

1. Do you notice any changes in your body afterwards eg, shortness of breath, racing heart etc?

REPITITION / COPING

It has been suggested that people who self-harm or attempt suicide more than once have difficulties in dealing with stressful situations

1. How do you typically deal with difficult situations?
 - Give me a recent example of a recent difficult situation, and how you dealt with that
2. When something stressful has happened do you get over it quickly or do you think about the incident for a long time? (day / weeks/ months)
3. When you are dealing with a difficult situation, do you worry about what others will think of you?
4. Did you find that after the first time you self-harmed it became easier to do it again?
 - Can you tell me a bit about that?
5. What do you think is most likely to lead you to self-harming again?

6. Can you describe a time when you have been able to stop yourself from self-harming?
7. What do you think is most likely to stop you from self-harming again?

DEVELOPMENTAL FACTORS

Previous research suggests that people who self-harm often have a history of childhood trauma e.g. parental separation, sexual / physical abuse and neglect

1. Is there anything in your background that might have made it more likely that you would self-harm?
2. What was life like for you growing up?
 - In what way have your childhood experiences have affected you as an adult?
 - Do you think your self-harm is related to your childhood experiences in any way?
3. What was your relationship like with your parents?
 - Which parent did you feel closest to and why?
 - Why not the other parent?
4. Has anyone else in your family self-harmed?
 - Who?
 - Can you tell me more about it?
 - How do you think it affected you?
 - Do you think that this may have influenced your self-harming? In what way?

GENDER

We know that more women go to professionals after self-harming or attempting suicide than men

1. Why do you think this is?
2. What do you think other people think about men who self-harm?
3. Do you think that men who self-harm are seen differently to women who self-harm?
 - Why do you think this is?

4. Do you think that men and women self-harm for different reasons?
 - What are these differences?
 - Why do you think this is?

INTERVENTION

Many people who have self-harmed have not had help from professionals, or have not found treatment helpful.

1. Have you ever had professional help for self-harm? Could you tell me about it?
2. Was it helpful? What about it was helpful / unhelpful? How could it have been better?
3. Did you stay in treatment / therapy? What led to you dropping out?
4. What do you think is the best way for professionals to help men who have self-harmed?
5. What things do you think may discourage men from seeking professional help for self-harm?
6. What do you think might encourage men to seek help for their self-harm?

That brings us to the end of the interview.

- *How are you feeling right now?*
- *Has the interview brought back any memories or feelings that you are finding difficult to cope with?*

Thank you for taking part in the study.

APPENDIX J

INITIAL OPEN CODING FOR PARTICIPANT 4

RESEARCHER	For the purpose of this interview I'm going to be using the term self harm to describe any occasion in which you've purposely tried to hurt yourself, whether you've intended to commit suicide or not. OK? We know that people self harm or attempt suicide for many different reasons and in many different ways. How many times would you say that you've tried to hurt yourself over the course of your life?	
PARTICIPANT 4	I suppose actual self harm more than I can remember. Suicide 5 times. It was in the context of an actual suicide pact which was done outside of Rampton. It was sort of brought about by psychiatric symptoms and exacerbated by drugs. So once actually during the actual pact itself and 4 times immediately afterwards.	<i>Self-harmed more than can remember.</i> <i>Suicide = 5 attempts</i> <i>Suicide attempts associated with a suicide pact</i> <i>Suicide attempts attributed to psychiatric symptoms and drugs</i>
RESEARCHER	And those were times where you've intended to die?	
PARTICIPANT 4	Yeah, yeah, absolutely. The circumstances were that it was a very persecutory, delusional system, where myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that. I haven't made an attempt on my life since coming here. I certainly did, at times, I did feel like it, but also there was kind of a big voice, there was a big voice saying 'I really didn't want to do this any more'.	<i>Suicide attempts associated with persecutory delusional belief system</i> <i>During suicide pact both parties believed 'it was the best thing to do'</i> <i>Ambivalent feelings regarding whether to attempt suicide or not</i>
RESEARCHER	Was that your own voice or was that a voice you were hearing?	
PARTICIPANT 4	No, no, it wasn't a 'voice', I've never suffered any kind of voices, it was just a voice within me. When you do something like that you lose all sense of yourself. It was a big voice saying I really didn't want to do this any more, it was a big enough tragedy that one person had died, for another to die would be a worse tragedy. So instead what I did was fuel my resources into rebuilding my life, which was the main thing.	<i>'Lose all sense of your self'</i>
RESEARCHER	So, there have been 5 attempts where you've attempted suicide. I got the impression that there've been other times where you've hurt yourself but you haven't intended to die. Is that right?	

PARTICIPANT 4	Yeah, when I was in prison, I had a couple of occasions when I did self harm. The availability of objects to self harm with was very easy. For me, self-harm was something which was getting more routine and worse, as time progressed. Coming here there wasn't the availability. I was watched most of the time anyway, so I kind of got it out of my system. You know, I suppose I came to terms with my problems, which made me see that self-harming wasn't really a constructive form of dealing with it.	<p><i>Self-harmed in prison</i></p> <p><i>Greater availability of objects to use to self-harm in prison compared to Rampton</i></p> <p><i>Self-harm becoming 'routine' and 'worse' overtime</i></p> <p><i>Being under observation by staff broke the 'routine' of DSH</i></p> <p><i>Self-harm as a means of coping</i></p>
RESEARCHER	If you had had the opportunity here, to be able to self harm or attempt suicide, do you think that you would have?	
PARTICIPANT 4	When I first arrived within the first half an hour of actually arriving here I was found standing on my table in my room. I'm not entirely certain what I was thinking of doing, you know. But from that moment on for about the next 4 months I was on Level 3's which is where you have 1 or sometimes 2 people with you 24 hours a day. Looking back, it really helped, at times you kind of resented them, the nurses, because you didn't wanted to be followed about or you just wanted a bit of space, you know, but it worked, I'm still here today, So, as an actual preventative measure, it worked. So yeah.	<p><i>Would have self-harmed if had the opportunity early in admission</i></p> <p><i>Staff observation as helpful 'preventative measure', but resented at the time</i></p>
RESEARCHER	Thank you, that's been really helpful. How often would you say that you'd self harmed or attempted suicide, was it a weekly basis, monthly basis, or was it over the course of years?	
PARTICIPANT 4	Actual suicide, the actual attempts themselves, there was 1 attempt actually during the pact and then there was 4 attempts in the 2 days afterwards.	<i>Suicide attempts within days of each other</i>
RESEARCHER	Right, so it was within a fairly short space of time for you.	
PARTICIPANT 4	Yeah, within about 2 days. Self harm, as I said, it was really when I arrived in prison, it began with once a week and gradually it was every other day and then, you know, every day. It was getting more frequent and it was getting more severe, you know, even though in comparison to people who seriously self harm it wasn't particularly serious. I think if you have fallen into that pattern of it, it could have really ended up as something which was very serious, you know.	<p><i>Self-harm began in prison.</i></p> <p><i>Frequency of self-harm increased from once per week to every day.</i></p> <p><i>Severity of self-harm increased overtime</i></p>
RESEARCHER	It sounds as though you see self harming and suicide attempts as quite different things. I was wondering what the difference was for you.	
PARTICIPANT 4	Well, you learn within groups that self harm is, well you get the endorphins, which are the body's pain killers, which	<i>Taught within groups that DSH releases endorphins</i>

	<p>give you a rush. I suppose that when you do something like that there's a hell of a lot of hate for yourself and anger. There was a lot of anger at the world as well, you know, in general. So I think it was a very unhelpful kind of expression of that. The suicide, sorry what was the question?</p>	<p><i>DSH as an expression of self-hatred and anger at self and the world.</i></p>
RESEARCHER	<p>I was just wondering what you felt were the differences between attempting suicide and self harming, or whether you thought there was a difference.</p>	
PARTICIPANT 4	<p>Suicide, there is definitely a difference. With self harm it's more kind of a, it tends to be more of a personal thing, you know, especially with men. With suicide, it's more that you just don't want to live, for whatever reasons, you can't see any value in your life and you just want your life to end, you know.</p>	<p><i>Self-harm as 'private' and 'personal' for men</i></p> <p><i>Suicide – 'no value in your life'</i></p>
RESEARCHER	<p>Do you think that there's a difference in terms of how you actually go about hurting yourself?</p>	
PARTICIPANT 4	<p>Errm....</p>	
RESEARCHER	<p>I'm just saying that because some people have said to me that the times where they've actually attempted suicide, the methods that they've actually used have been more extreme than when they've self harmed.</p>	
PARTICIPANT 4	<p>Absolutely, yeah. You definitely know the difference between self harm and suicide when you're doing it, you know. You know with self harm that you aren't going to take your life, with the method you use, well I did anyway. With suicide you actually go out with the sole intent that that's what you're going to do, you know. Or attempt to. With actual suicide it's more calculated, you know. There's a hell of a lot of more planning goes into it, you know. So, yeah.</p>	<p><i>'You know the difference between self-harm and suicide when you're doing it'</i></p> <p><i>More 'planning' involved in suicide attempts</i></p>
RESEARCHER	<p>That's really interesting. OK. So how have you actually tried to self harm or attempt suicide in the past? Has it been things like overdosing?</p>	
PARTICIPANT 4	<p>When I attempted suicide I stabbed myself in the chest, I cut my wrists, I tried to overdose on paracetamols. There was an attempt, to electrocute myself, but I didn't quite have the courage, and I also tried to drown myself. With self harm it was mainly by cutting.</p>	<p><i>Method of suicide:</i></p> <ul style="list-style-type: none"> - <i>Stabbing self in chest</i> - <i>Overdose taking paracetamol</i> - <i>Electrocution</i> - <i>Drowning</i> <p><i>Method of self-harm:</i></p> <ul style="list-style-type: none"> - <i>Cutting</i>
RESEARCHER	<p>What did you tend to use to cut?</p>	
PARTICIPANT 4	<p>In prison it would be razor blades. I think that it was the kind of thing that I'd observed, you know. I suppose to a certain extent you see somebody else doing it and it's almost like copying behaviour, you know, I think that's true to a certain extent. I think, some of what I've observed,</p>	<p><i>Tend to use razor blades to cut in prison</i></p> <p><i>Observed others using razor blades to self-harm and</i></p>

	over sort of the women's side as well, is copying behaviour, they see one person doing it and they kind of copy that behaviour, you know.	<i>copying the behaviour</i>
RESEARCHER	Why do you think people might copy self-harming behaviour that they've observed in others?	
PARTICIPANT 4	That's an interesting one. I think it's because you see it working for them, do you see what I mean?	<i>Copied others methods of DSH as it appears to be 'working for them'</i>
RESEARCHER	Yeah, it's kind of seeing that other people use that as a means of coping and thinking perhaps that would be useful for me as a way of coping as well.	
PARTICIPANT 4	Yeah, or somebody advising them that that is a good way to cope.	<i>Being advised by others that DSH is a good way of coping</i>
RESEARCHER	Right, so were you given that advice?	
PARTICIPANT 4	I wasn't given that advice, but you know I have in the time I've been here, I've been here for 11 years, and from what I've observed it does happen, yeah. People tell each other to do it	<i>Being advised by others that DSH is a good way of coping</i>
RESEARCHER	OK. So when was the last time that you self harmed, or attempted suicide?	
PARTICIPANT 4	It was a good long time ago. It must be nearly 10 ½ years ago since I self harmed.	<i>Last episode of DSH approximately 10 years ago</i>
RESEARCHER	So how old were you the first time that you tried to hurt yourself?	
PARTICIPANT 4	Oh, erm, I suppose when I was at school there was a couple of times where I didn't really kind of feel that it might help and it was, I suppose, more for attention, or, you know how teenagers are very kind of like - heads very all over the place, you know what I mean. But there was a couple of times when I made scratches on my arm.	<i>DSH as a teenager for 'attention'</i> <i>Made scratches on arm as a teenager</i>
RESEARCHER	How old were you?	
PARTICIPANT 4	I suppose I'd be about 15. But there was a real lot going on in my life, you know. I was really quite stressed at the way things had turned out in my life and very confused with life and, very down with life as well, I think I was a bit depressed to be honest.	<i>Aged 15 at first episode</i> <i>At first episode:</i> - 'stressed' and - 'confused' about life - Depressed
RESEARCHER	How would you describe what was going on in your life at that time, when you were 15, the very first time that you scratched your arm?	
PARTICIPANT 4	Not understanding what life was about, you know, getting very involved with myself. Really not understanding myself either, what I was about or where I was going or, the value or worth of life. Being totally kind of divorced from	<i>'getting very involved with myself'</i> <i>Not appreciating the 'value</i>

	your own self, you know, being very unsure about everything.	<i>of life'</i> <i>Feeling 'Divorced from myself'</i>
RESEARCHER	It sounds as though you became quite introverted.	
PARTICIPANT 4	Yeah, I think that's true, yeah. I think people do go into themselves because that's the kind of way of coping with things, you know. I think, it's a way of coping with things, you kind of shut yourself away from things that potentially hurt you and you become very obsessed in your own thinking, kind of brooding, very dark thoughts, very morbid thought patterns, you know. I think also depression features a lot in it, you know.	<i>'Going into self' – shutting your away from hurt, and begin ruminating about 'dark thoughts'</i> <i>Depression</i>
RESEARCHER	I was just wondering, what was your relationship was like with your friends and family at that time when you were 15?	
PARTICIPANT 4	My relationship with my family was not good, not good at all. There was a great deal of kind of upheaval in the family. There wasn't really any support or, I didn't feel as if there was any emotional content in the family, looking back at the time I didn't quite understand it, you know. But my parents were very busy with their lives and my brother was very busy with his life and, for me I was very sensitive and didn't feel as if I really fit in or understood what anything was about, you know.	<i>Poor relationship with family</i> <i>Lack of emotional support within family</i> <i>Didn't fit into family</i>
RESEARCHER	It sounds as though it was a difficult time for you and it sounds as though you felt that you were different to your family. Have I understood that right?	
PARTICIPANT 4	Yeah, very much so, very much so. I didn't really have any close friends that I could have turned to for support, you know. I really felt as if I was cast out in the world by myself, you know. So it was a very difficult time, very difficult time. There was a couple of times when I did, not seriously, self harm, but you know just self harmed you know. I think it was more of a cry for help, for attention, you know, rather than getting the actual relief or anything. I think it was just a very difficult time for me at the time, you know, and as a result I turned to drugs to cope with it in later life, you know.	<i>No close friends to turn to for support</i> <i>'cast out into the world by myself'</i> <i>DSH as a 'cry for help' and 'attention'</i>
RESEARCHER	That was going to be my next question, actually. Were you taking any drugs or were you drinking around the time that you very first tried to hurt yourself, so when you were 15?	
PARTICIPANT 4	I certainly wasn't taking any drugs. As for drinking, not seriously, very rarely. Almost never really. It wasn't something which came into my sphere, nobody at my school took drugs, some people occasionally drank, you know, at parties and things like that, it was a big thing to sort of get drunk and have a drink...	<i>Was not taking drugs or drinking prior to first DSH</i>
RESEARCHER	Yeah, when you're 15 it is quite a big deal isn't it?	
PARTICIPANT 4	Yeah, it is, but you know, you'd never drink outside of	<i>Not being able to see a way</i>

	those kind of scenes. So, there was never that way of kind of like dealing with things at that age, you know. It was more it was a bit of a prison I'd got myself into in my own mind, I couldn't really see beyond the bars you know really.	out - <i>"It was more it was a bit of a prison I'd got myself into in my own mind, I couldn't really see beyond the bars"</i>
RESEARCHER	I really like that way of describing it.	
PARTICIPANT 4	Yeah, well I think that's very true, you know. I mean it sounds a bit corny but it's a famous philosopher who said, bars do not a prison make, you know, bars in your mind, that's what the prison is. It doesn't take very much to be free of them, just to kind of like shed it off.	
RESEARCHER	That's a very philosophical outlook	
PARTICIPANT 4	(laughter)Thank you.	
RESEARCHER	So what happened in the lead up to you first self harming episode?	
PARTICIPANT 4	When I was 15? It's a long time ago, I can't remember exactly. I've never really seriously thought about it you know. I think there was a lot of pressure at school, I think there was exams coming up. I was in my final year, so really people were starting to be streamed into the various things that they were doing, and I didn't really know what I wanted to do. So there was a lot of pressure on you to make those choices and decisions about your life, I really didn't have much clue about what I wanted. I was getting no real encouragement at home to do this or to do that or to be this or to be that.	<i>Not really thought about what happened in lead up to first episode</i> <i>School pressure – exams coming up</i> <i>Didn't know what he wanted to do with his life – pressure to make decisions</i> <i>No 'encouragement' from family</i>
RESEARCHER	So once again it was another situation which you felt very much on your own.	
PARTICIPANT 4	Yeah. It's just like, you kind of got used to school for the best part of 10 years, you know, and then you're going to be kicked out and the rest was up to you.	<i>Unsure of what to do after formal education ended</i>
RESEARCHER	Yeah, and what do I do with the rest of my life now?	
PARTICIPANT 4	Yeah, yeah. I just felt totally unprepared. I had people at school and they were doing this or doing that and I was by myself doing nothing, you know, so I just didn't feel as if I was part of anything I suppose. I didn't feel as if I was part of a family or had friends, or part of school even, I just didn't feel as if I was a part of anything, so I just felt totally isolated and by myself, you know.	<i>Feeling 'unprepared' for life</i> <i>Not feeling part of family</i> <i>No friends</i> <i>Isolation</i>
RESEARCHER	And I guess that would have led to you becoming more and more introverted in a sense.	
PARTICIPANT 4	Absolutely, absolutely. Yeah, yeah. As I say I think I did become quite depressed, you know, looking back.	<i>Becoming depressed</i>

RESEARCHER	Do you think you were experiencing, I know that you've mentioned depression, do you think that you were experiencing any mental health problems around that time?	
PARTICIPANT 4	Apart from depression, no. There was certainly nothing delusional or anything like that, you know. I think that I was more kind of, you know, brought on by actual drug use later on in life.	<i>No MH problems other than depression</i>
RESEARCHER	Right, OK. Do you remember anything significant that made you think about self harming that first time?	
PARTICIPANT 4	I do actually, yeah. It might sound a bit corny and a bit silly. I remember at the time there was a resurgence of the Sex Pistols and Johnny Rotten and lots and lots of talk of him, kind of being this idol and this god and you know doing all these stupid things on stage, do you see what I mean? It sounds a bit silly looking back but I do remember that at the time. I don't know if that's what influenced me, but I do remember that at the time. You know. Maybe it comes back to that thing where you kind of see somebody doing it so you kind of like think that might be a way of dealing with things.	<i>Observing others: Thought about Johnny Rotten cutting and thought that might be a way to 'deal with things'</i>
RESEARCHER	Yeah, I guess at 15 it probably seemed quite cool, in a sense.	
PARTICIPANT 4	Looking back I thought, well that sounds a bit cool, like, you know. I think it was a bit of attention, you know, more than anything else, you know.	<i>Cutting 'sounding cool' DSH for 'attention'</i>
RESEARCHER	As you said, a cry for help, if you're feeling quite isolated from school and friends and family, I guess it was a bit of a cry for attention, you know somebody pay attention, I'm not feeling quite right.	
PARTICIPANT 4	Yeah, that's what it is, it's a very, you know looking back, it's a very unhelpful kind of a way to express the pain you're feeling, you know. It's certainly very, very unhelpful, you know. I think some people do fortunately get out of it, you know, or kind of get into it at a young age and then get out of it, you know. It does certainly get worse, you know, if it becomes very fixed then it does certainly get worse as you get, as people go along, you know, it gets more and more severe with more and more kind of, you know, less and less time in between them, in between each self harming, you know.	<i>DSH as an unhelpful way of expressing pain DSH as something you can 'get out of' Increase in severity and frequency as time progresses</i>

Change of tape

RESEARCHER	OK, still thinking about the very first time, how long did it take you to make the decision to hurt yourself?	
PARTICIPANT 4	I remember being in my room, being in a swamp in my mind, with a heavy head, all these worries and anxieties booming through my mind, you know, and not knowing what to do with them. And it was almost like being, I suppose, a bit drunk almost like being intoxicated with it all, just a quagmire in your mind, my head was spinning,	<i>Cognitive component prior to DSH Ruminating - 'swamp in my mind'</i>

	and it was literally on the turn of that that I think I first self harmed.	- 'worries and anxieties booming through my mind'
RESEARCHER	So was it that you'd thought about it and continued to think about it before you did it, or was it on the spur of the moment?	
PARTICIPANT 4	I think there was certainly a bit of a lead up where I was getting more and more into my thinking. It's these obsessive mind patterns, where you think of something once and then the next time you think of it you spend a bit more time thinking about it and then the next time, it kind of carries on like that, and you kind of like do something about it, you know. I got to the eventual stage where it was like hanging over my head and hanging over my head and hanging over my head, you know. And it was just, it was almost like "I'll try it to see what it does, see if it helps, see if it works".	<i>Lead up in which 'I got more and more into my thinking'</i> <i>Description of ruminating process which ends in a decision to DSH</i> <i>Exploratory DSH - curiosity to see if it helps?</i>
RESEARCHER	So in a sense it was kind of exploratory for you, is this going to help or not.	
PARTICIPANT 4	I suppose to a certain extent it might have been, but I also think, as I said before, it was certainly a cry for attention and help. Certainly that and very obsessive, initially you're like "right I've thought of it", then the next time I think of it it's like, "hold on", the next time, you know you are going to do it. And it's almost like it's a bit of a relief for my mind. My mind was getting heavier and heavier and everything else was crowding in and then there was the depression as well and I was just feeling absolutely to bits with myself, you know.	<i>Description of ruminating process prior to DSH</i> <i>DSH as a 'relief for the mind'</i>
RESEARCHER	Just overwhelmed by everything.	
PARTICIPANT 4	Yeah, overwhelmed with everything. I suppose it was maybe the one thing in my life I could control at the time, you know. I don't know, I don't know.	<i>DSH as the one thing participant could control in his life</i>
RESEARCHER	Do you think that that was an aspect of it, having some control over your life when it appeared that you didn't have control over the rest of your life?	
PARTICIPANT 4	Yeah to some extent I think it might have been, yeah. Like actually making a decision in your life when, you can't really decide about anything else, you know.	<i>DSH as 'making a decision in your life when you can't really decide about anything else'</i>
RESEARCHER	And in a strange way a bit of success because you have been able to make a decision?	
PARTICIPANT 4	Well, I'm not so certain about actual success, you know. I think, looking back, it did give me a bit of relief from it, because of the way it was kind of a turmoil in my mind, it kind of gave me relief from it for a bit, you know.	<i>DSH as a means of controlling thoughts – 'it was kind of a turmoil in my mind, it kind of gave me relief from it for a bit'</i>
RESEARCHER	Did those, sort of more obsessive thoughts come back after you'd self harmed?	

PARTICIPANT 4	I think they did maybe a couple of times. I think there was a couple of times when I actually did self harm when I was about 15, but after that I think things began to pick up in my life anyway, I started making some decisions about what I wanted to do with my life, so I kind of got out of the pattern. There was no real support at my school, for that kind of thing as there is now. No real support networks that I was aware of and I suppose back then I didn't really think I had a problem anyway, you know, you see what I mean?. I wouldn't have sought out help because I just wouldn't have perceived myself as having a problem with it. It was just something I did, you know, spur of the moment because I thought it might make me feel good or worse, like, you know, do you see what I mean. It might sound very strange but really you've got to remember I was a very confused, very mixed up teenager, who really was in a quagmire in his mind at that time, you know. I literally felt I was kind of suffocating with it. I didn't understand life, what it was about, where I was going, you know, anything like that.	<i>A couple of DSH episodes as a teenager</i> <i>Didn't view DSH as a problem as a teenager, so wouldn't have sought out help</i> <i>DSH on spur of the moment</i>
RESEARCHER	OK. How much planning did you actually put into self harming the first time, or did you not put any planning in at all?	
PARTICIPANT 4	I can't even remember what I self harmed with, you know. It was a long time ago and I haven't really seriously thought about it in as much depth as I just have now. I've never really sort of returned to it, you know. I think it was just a bit of sharp metal, you know. Like I say it was just scratches really, you know, sort of parallel lines, you know.	<i>Not seriously thought about first episode in much depth</i> <i>Used a sharp piece of metal to make scratches during first episode</i>
RESEARCHER	Was that a piece of scrap metal something that you found or was it something that you fashioned?	
PARTICIPANT 4	I think it was something I found and thought, "you know, that'll do it". I can't even remember what it was, I think it might have been a broken paper clip or something like that, you know. I think it might have been something like that.	<i>Sharp piece of metal was something he found – broken paperclip</i>
RESEARCHER	Did you discuss what you were going to do with anyone else that first time?	
PARTICIPANT 4	No. No absolutely not.	
RESEARCHER	What were you thinking or telling yourself just before you did it?	
PARTICIPANT 4	Erm.... as I said it was definitely a cry for help and that's what I was thinking just before hand, you know, "if somebody sees this expression of what's going on in my mind, then surely they'll talk to me and they'll ask me what's going on, they'll sort of say to me - look what you're doing, tell me what's going on". Nobody did, so, (laughter) you know.	<i>Cognitions during first episode:</i> <i>Someone to talk to me and seem to care</i>
RESEARCHER	So in a sense you were kind of hoping that, by doing this, somebody would recognise that things weren't right with you.	

PARTICIPANT 4	Yeah, my parents or someone.	<i>Hoping that parents or someone would recognise that things were not right</i>
RESEARCHER	But nobody did.	
PARTICIPANT 4	No nobody did, no.	
RESEARCHER	It sounds as though you imagined how other people might respond to your self-harming. Is that right?	
PARTICIPANT 4	Definitely, as I said it was a cry for help, you know. I imagined in my mind at the time, I suppose I imagined somebody might take pity on me (laughs), you know show me some attention. I was a very confused lad. But I think that was basically it, yeah, "show me some attention, please!"	<i>Imagined how others would respond to DSH – 'someone might take pity on me', 'show me some attention'</i>
RESEARCHER	Did you have any second thoughts about doing it as you were doing it?	
PARTICIPANT 4	I think I did ask myself what I was doing this for. Yeah. I think I did, at the time I thought "what am I doing? What am I doing here? This is crazy". I think that just added to my confusion	<i>Asked self 'why am I doing this'</i> <i>Ambivalent feelings added to confusion in mind</i>
RESEARCHER	Did you recognise any changes in your body, such as your heart beating faster, or your breathing becoming more rapid as you did it?	
PARTICIPANT 4	I suppose, thinking back I did kind of feel a bit buoyed after doing it, you know, which might have been kind of the rush of endorphins as has been explained to me in various groups and things. There was certainly a sense of relief, you know, so it might have been that, you know.	<i>Post DSH:</i> - <i>felt 'buoyed'</i> - <i>relief</i>
RESEARCHER	What actually brought the episode of self harming to an end then?	
PARTICIPANT 4	I think things were improving in my life. I had, I think, I think I might have got, I think, yeah, I had started having a relationship with a girl at work, I was working, so I think that picked me up a bit, you know.	<i>Life 'improving' ended routine of DSH ie having romantic relationship</i>
RESEARCHER	What about when you were actually scratching your arm, what brought that to an end?	
PARTICIPANT 4	Yeah, I think that was it, kind of, you know, things were beginning to sort themselves out in my life, it was all a bit, I had sort of decided where I wanted to go in my future, you know, I wanted to go into the army and I was beginning to leave some of the attachments of school behind. I was beginning to see a bit of a future for myself, added to which, I started having a relationship with a girl I met at work, she was a really nice lass, I've never spoken really to anybody about this, you know. I think things just began to sort of improve in my life really. At home things didn't improve.	<i>Life 'improving' – decided wanted to join army, relationship started up.</i> <i>Family life did not improve</i>

RESEARCHER	But other aspects of your life were improving?	
PARTICIPANT 4	Yeah, yeah I think so. I think I began to sort of feel a bit more normal again, you know.	<i>Beginning to feel 'normal' again</i>
RESEARCHER	And I guess as you said, seeing that you had a future.....	
PARTICIPANT 4	Yeah, yeah, whatever that future may be. It just removed some of the uncertainty and crises from my life, you know.	<i>Gaining a sense of direction for the future as a helpful intervention</i>
RESEARCHER	So could you describe how you were feeling emotionally as you self harmed – were you feeling excited, nervous, calm, happy?	
PARTICIPANT 4	Yeah, it was a long time ago. You know you tend to remember thoughts more than feelings don't you?. I was resolute in my mind, but at the same time I was thinking "what am I doing this for?".	<i>Ambivalent feelings regarding DSH</i>
RESEARCHER	Did those feelings change as you were doing it?	
PARTICIPANT 4	I think there was a sense of relief as I described, which I think might have been the endorphins, the pain killers. I think there was a sense of relief, yeah.	<i>Post DSH a sense of relief</i>
RESEARCHER	OK. What exactly happened immediately after you self harmed for the first time?	
PARTICIPANT 4	I can't remember exactly. I think I felt a lot better about things.	<i>Post DSH felt 'better'</i>
RESEARCHER	Someone else I spoke to described just carrying on with life as normal afterwards, as though it had just been a blip in a sense. Was that similar to your experience?	
PARTICIPANT 4	Absolutely. It was just like, I gave it no more thought, you know. I feel a lot better about myself, great, that's the important thing. I think I probably put on some music (laughs), you know, turned it up loud. I think, as I say, I think the thing at the time was that I felt better about things, you know. The kind of pressure that I was under before I self harmed was suddenly, it just evaporated, it'd just gone into like the atmosphere. I think I felt quite light and buoyant.	<i>Post DSH 'gave it no more thought' – Blip?</i> <i>Post DSH put music on</i> <i>Pressure lifted post DSH felt 'light and buoyant'</i>
RESEARCHER	More carefree in a sense?	
PARTICIPANT 4	A bit elated more than anything else, you know, because it's just like, you know, oh I feel so much better after that, you know. Yeah, I think that's it. But of course, you know, it doesn't last of course, you know, because it's not a very constructive way of kind of dealing with things, you know. I think within hours, you know, I was back in the quagmire of my mind again, you know.	<i>Post DSH felt 'elated'</i> <i>Post DSH felt 'so much better'</i> <i>Positive effects of DSH do not last, back to pre DSH state within hours</i>
RESEARCHER	But for a very short space of time self-harm gave you a temporary relief from that.	
PARTICIPANT 4	It did, a relief, yeah, I think so, looking back yeah, yeah.	

RESEARCHER	Did your friends and family ever find out about that first time? Did they ever become aware of it?	
PARTICIPANT 4	Weeks later, many weeks later. One of my parents, I can't remember who, I think it was probably my Dad, asked "how did you get those marks?" And I said "oh I did them in the gym". That's all that happened. I explained it that way, you know.	<i>Parents discovered DSh weeks later.</i> <i>Lied to conceal true reasons for marks on arms</i>
RESEARCHER	So in sense you had told a bit of a lie?	
PARTICIPANT 4	I did, yeah, yeah.	
RESEARCHER	Had there been other times when you self-harmed that you'd had to sort of lie to other people about what the marks might be or ...?	
PARTICIPANT 4	I never really self-harmed apart from them 2 occasions when I was 15. I never self-harmed for the rest of my life until I went into prison, when I was 20. But in prison I was self-harming on my chest, so people couldn't see, they weren't aware what was going on.	<i>DSH ended for 5 years</i> <i>DSH on chest so 'people could not see'</i>
RESEARCHER	Was that a purposeful thing then ...?	
PARTICIPANT 4	It was, it was.	
RESEARCHER	So that others couldn't know?	
PARTICIPANT 4	Yeah, it was, yeah. I didn't want the attention, you know. I didn't want the kind of attention that went with it. It's more a private thing, you know. It's just a weird way of dealing with anger and hatred and self-loathing that I felt. It was a moment of relief for me.	<i>Not wanting attention associated with DSH</i> <i>DSH as 'private'</i> <i>DSH as a means of dealing with anger and hatred and self-loathing</i> <i>DSH as a 'moment of relief'</i>
RESEARCHER	So, the first time it was about actually calling attention to yourself but then once you were in prison it was much more private ...	
PARTICIPANT 4	It was.	
RESEARCHER	... and you didn't want that attention?	
PARTICIPANT 4	Yes absolutely, yeah, yeah. The first time I wanted people to notice that something was wrong but after that I didn't want the attention that came with it.	<i>Evolution of function of DSH – began as a call for others to notice and became an act of self-punishment</i>
RESEARCHER	Ok. Do your friends and family know about your self-harming or attempting suicide?	
PARTICIPANT 4	Yeah.	
RESEARCHER	What do they think about it?	

PARTICIPANT 4	They were aware of the suicides, when I came here, they sort of said “when you were in prison, you were just all over the place, you know. We just didn’t understand what was going on with you at all. You were covered in bruises and cuts and every time we came up to see you you’d have a black eye you know, from fighting and things like that”. Obviously they knew about the circumstances of my offence because I’d explained it to them and we’ve been open and discussed it over the years. I don’t know whether they were aware of the self-harming aspect or the extent of it, but they were certainly aware of the attempted suicides and things like that, yeah, definitely.	<i>Family not understanding DSH</i> <i>Family aware of suicide attempts but not self-harm.</i>
RESEARCHER	What did they think about it, or how did they respond to you?	
PARTICIPANT 4	I think when I was in prison they were absolutely distraught, they just wanted me to get help for the things I was going through. Really they didn’t understand and I couldn’t talk about it, As I said they didn’t really understand what I was going through, they couldn’t quite rationalise it, they just didn’t have the kind of the knowledge they have now. So they just didn’t understand what was going on in prison	<i>Family didn’t understand and participant couldn’t talk about it</i>
RESEARCHER	But at the time they just didn’t really understand what you were doing?	
PARTICIPANT 4	Obviously they thought I “wasn’t right” which they said to me you know. They said “you weren’t right obviously you know but we just didn’t understand what was wrong with you ... we just didn’t have that kind of knowledge you know. Even today I have to kind of like re-explain things to them, regarding the illness. For example, last time, not last time the time before when they came up, I had to re-explain what “an enduring mental illness” was. It was explained to them in the past but it’s harder for them to grasp you know because, it must be a bit of strange concept for them I suppose ...	<i>Family thought ‘I wasn’t right’ which they said</i>
RESEARCHER	Whereas I guess you’ve got used to the these concepts	
PARTICIPANT 4	Absolutely. I mean I’m in the thick of it, so I’ve just had to kind of like you know take it absolutely on board, you know ...	
RESEARCHER	Yeah	
RESEARCHER	Do you think that your self-harming and your suicide attempts had an impact on your relationship with your family?	
PARTICIPANT 4	My parents all the way through this have been very supportive, very supportive, although at times I haven’t seen it as such you know due to the illness. Erm, on reflection they have been very, very supportiveat times I’ve really resented them for it you know. It’s been very, very difficult for them over the years, very difficult. Erm, what was I going to say? Oh yes, I’m very lucky to have	<i>Parents have been supportive but participant didn’t recognise this at the time</i> <i>Resented family support at times</i>

	the kind of parents that I have got, you know who are as supportive as they are.	
RESEARCHER	But at times it hasn't felt that way?	
PARTICIPANT 4	Exactly.	
RESEARCHER	Yeah, ok. I'm going to ask you some questions about your self-harming or the suicide attempts in general. When you felt like self-harming, is it a slow build up of things, or is it one thing that will set you off?	
PARTICIPANT 4	I think it's a slow build up of things.	<i>Slow build up of things</i>
RESEARCHER	Right.	
PARTICIPANT 4	Erm, when I was in prison yeah, it was a slow build up of things. I was under a great deal of pressure you know, a great deal of pressure, not just trying to deal with the reasons why I'd come in to prison but also the illness and there was so many other things to deal with you know. It was just a gradual building up of pressure you know and self-harm was almost like, pulling the thing on the kettle you know, the whistle. You know what I mean? Instead of like boiling with it, you just let the steam off you know.	<i>Gradual build up of pressure and DSH releasing pressure – kettle analogy</i>
RESEARCHER	Do you ever get the urge to hurt yourself?	
PARTICIPANT 4	No, not any more, not any more.	
RESEARCHER	Did you in the past?	
Change of tape		
RESEARCHER	So the question was, have you ever had the urge to self-harm in the past?	
PARTICIPANT 4	In the past, how do you mean?	
RESEARCHER	Erm, over the course of your life, when you have self-harmed, has it been that there has been an urge to do it?	
PARTICIPANT 4	Right I think I understand. I think the first time I self-harmed when I was a teenager, I think it was the urge, there was an urge there, and again in prison when I self-harmed after a long period of not doing it.	<i>Urge to do it</i>
RESEARCHER	Right, yeah.	
PARTICIPANT 4	It was almost like a compulsion in my mind you know. With all the pressure that was going through my mind and then you start imagining your self-harming you know and then you can't get the thought out of your mind, it's almost like an obsessive thing.	<i>DSH as a means of controlling thoughts and releasing pressure.</i>
RESEARCHER	Right.	
PARTICIPANT 4	It was like, I keep on thinking about this thing and I don't want to do it but you know, every time you think about it,	<i>Ruminating on thoughts of DSH – urge to DSH</i>

	the urge, the compulsion gets greater and greater you know, until you actually do it and then, it was a bit of a release, a very unhelpful kind of way of dealing with things but it was a release...from everything and so it was kind of at that point that it came a bit of a habit almost it was a solution to kind of deal with the pressure you know.	<i>increases – DSH – release</i> <i>DSH as a means of dealing with pressure.</i>
RESEARCHER	Right. Do you think you were able to control those urges or compulsions? Is it something that you felt was within your control?	
PARTICIPANT 4	Umm (long pause). I think if I hadn't had as much on my mind as I did then I would have been able to control those urges quite easily. But with everything which as kind of weighing down and weighing down and weighing down on me, it was kind of like "well if I actually do it, then that's one less thing that I've got to worry about.". Do you see what I mean?	<i>Unable to control urge due to 'everything weighing me down'</i> <i>DSH means one less thing to worry about</i>
RESEARCHER	Could you give me more details?	
PARTICIPANT 4	I think self-harming becomes very obsessive in your mind. What I mean by obsessive is that, you have a train of thoughts and you'll actively engage in that train of thoughts, where thing then leads to another and another... it's just like a train with carriages. You know and every time you return to the thought, you fit in another carriage Do you see what I mean?	<i>Description of ruminating on DSH process</i>
RESEARCHER	Yeah, yeah that makes sense.	
PARTICIPANT 4	Yeah, it's like if you have an anxiety about anything really, you know you could be going to a job interview, you might think that this can go wrong, then you leave it at that. Then the next time you think oh this might go wrong as well and you leave it that and then the next time you think about it, this might ... every time you know that you travel back seeing that same pattern of carriages where this can go wrong and this can go wrong, and then you think this might go wrong as well.	<i>Comparison of DSH rumination process to job interview anxiety</i>
RESEARCHER	Yeah. So you are sort of adding to that initial anxiety and just increasing that anxiety with each thought	
PARTICIPANT 4	Yeah. So it becomes almost like an obsession in engaging in ...	
RESEARCHER	Yeah.	
PARTICIPANT 4	Do you see what I mean?	
RESEARCHER	Something that you can't let go because you have to sort of go through this pattern each and every time?	
PARTICIPANT 4	Yeah. Back when I was teenager and I first self-harmed, it was like "if I actually do it, then I can remove one of those carriages". So that's why I think why I did it. It was almost kind of like I wouldn't have to think about it anymore you know. Almost, you know, sort of why it was the urge ...	<i>Engaged in DSH so would not have to think about it anymore.</i>

RESEARCHER	Yeah...and just gets rid of those thoughts because you'll have done it then?	
PARTICIPANT 4	Yeah, yeah.	
RESEARCHER	How interesting.	
PARTICIPANT 4	(Laughter).	
RESEARCHER	Um, I just wanted to go back to something that you said earlier, that you said that it became like a habit for you	
PARTICIPANT 4	Uh huh.	
RESEARCHER	Could you ... can you explain that to me in a bit more detail?	
PARTICIPANT 4	Erm, I suppose what I mean by habit is it's almost like a compulsion, you know, it becomes a coping skill.	<i>DSH becomes a coping skill</i>
RESEARCHER	Mmm.	
PARTICIPANT 4	You know, I suppose it was a coping skill for me back then, to deal with the pressure. I mean the self-harm, the self-harm was a coping skill. So when all the pressure built up, the coping skill, the habit you know, that's what I mean by habit ...	<i>DSH as a coping skill to deal with pressure which becomes habit forming</i>
RESEARCHER	I guess that when you said that it made me think of something that somebody else had said, that it became a bit like an addiction ...	
PARTICIPANT 4	No, not, not like an addiction ... It was certainly a coping skill.	<i>Not an addiction DSH is a coping skill</i>
		<i>Are participants referring to same phenomena when discussing DSH as a habit forming coping skill and as addictive? Both refer to a sense of relief from the pressure of thoughts?</i>
RESEARCHER	Right.	
PARTICIPANT 4	Erm but it wasn't an addiction.	
RESEARCHER	Right.	
PARTICIPANT 4	I think for some people it can be kind of become a bit of an addiction, if they do it for long enough and it's the first thing that they use to cope.	<i>DSH can become an addiction if engaged in over a long period of time and is primary coping method</i>
RESEARCHER	But that wasn't your experience.	
PARTICIPANT 4	But that wasn't my experience no. I wasn't addicted to it, no, no.	
RESEARCHER	Ok.	

PARTICIPANT 4	It was just a way of coping for me you know.	<i>DSH as a means of coping</i>
RESEARCHER	Yeah.	
PARTICIPANT 4	It was just a way of releasing the pressure, you know.	<i>DSH as a means of releasing pressure</i>
RESEARCHER	At times when you've self-harmed or attempted suicide in general, what's usually been happening in your life?	
PARTICIPANT 4	Erm ... what you mean the common factor?	
RESEARCHER	Yeah, if there are any commonalities that you can identify?	
PARTICIPANT 4	Absolute confusion.....persistent confusion. ...(long pause), I suppose there was certainly a sense of not caring any more, you know just, just not caring any more.	<i>Generally feeling:</i> - <i>confused</i> - <i>not caring anymore</i>
RESEARCHER	Hmm.	
PARTICIPANT 4	Not caring what happens to myself or my body you know. Erm, yeah.	<i>Not caring about 'what happens to myself or my body'</i>
RESEARCHER	How did you feel about, how do you feel about yourself generally around those times?	
PARTICIPANT 4	My attempted suicides were a bit different, so we'll use self-harm. Erm, I suppose I was very divorced from myself. The first time and later on in prison, it was really circumstances that I didn't quite understand in prison. I was becoming ill again and circumstances that I didn't quite understand that I just couldn't get my head around at all you know.	<i>'Divorced from myself'</i> <i>'couldn't get my head around' things</i>
RESEARCHER	What about the times where you've attempted suicide?	
PARTICIPANT 4	What was that ...?	
RESEARCHER	What was usually happening in your life around the times that you've attempted suicide?	
PARTICIPANT 4	Erm, well I'd just committed the offence. I suppose the common thing was just that I just wanted to die, just didn't want to carry on you know.	<i>'Just didn't want to carry on'</i>
RESEARCHER	Were you in prison at that time?	
PARTICIPANT 4	No.	
RESEARCHER	Right.	
PARTICIPANT 4	That was when I was on the outside. I just didn't want to carry on any more.	<i>'Just didn't want to carry on anymore'</i>
RESEARCHER	It sounds as though you felt a lot of self-hatred at that time, would that be fair to say?	
PARTICIPANT 4	Erm ... (long pause) I don't think there was self-hatred, erm	

... (long pause), I think it was just like erm, my brain's beginning to run numb. (laughter). I could do with a cigarette you know.

RESEARCHER Yeah. Do you want a cigarette break?

PARTICIPANT 4 Could I?

RESEARCHER Of course you can.

PARTICIPANT 4 Great.

Participant 4 returns after a cigarette break

PARTICIPANT 4 Ok – where were we?

RESEARCHER I was just about to ask you, typically when you happened to try to hurt yourself ...

PARTICIPANT 4 Yeah.

RESEARCHER ... had you been drinking or taking drugs beforehand?

PARTICIPANT 4 Erm no.

Not typically misusing substances during DSH

RESEARCHER No.

PARTICIPANT 4 Not when I attempted suicide. In prison I was using cannabis ... probably some of those nights did coincide with when I did self-harm.

Sometimes using cannabis during DSH episodes

RESEARCHER It sounds that you don't feel that they were related in any way?

PARTICIPANT 4 No, I don't think so. I don't believe so.

RESEARCHER Ok. Were you experiencing any mental health problems around the times that you tried to hurt yourself, whether they be suicide attempts or self-harming?

PARTICIPANT 4 Absolutely. When, I suppose when I was teenager there was a certain amount of depression. When I attempted suicide both myself and my partner were absolutely inundated with delusions of persecutions and paranoia, to the extent that we believed that we only had like minutes to live ...

Depressed during first DSH episode

Delusional and paranoid during suicide attempts – believed had only minutes to live

RESEARCHER Uh hmm.

PARTICIPANT 4 You know, to the extent that we believed that we only had like minutes to live ... we were absolutely in a terrible state when we decided you know, on the course of action we did. In prison, I was starting to become ill again, mainly because I believe the cannabis use. So there is a definite correlation between mental illness and kind of self-harm ... so there is a definite correlation between mental illness and self-harm in my mind...

Correlation between MH problems and DSH

RESEARCHER	What about suicide attempts?.	
PARTICIPANT 4	Suicide, yeah. Definite correlation.	
RESEARCHER	I know that you said that you were in a suicide pact ... and there was a delusional belief that you possibly only had minutes to live ... So was attempting suicide, a way of stopping what you saw as being inevitable or having some control over it?	
PARTICIPANT 4	It was more a case of, we believed that when these people did get us, then they were going to really, really you know hurt us in bad ways you know. So we thought the best way would be just to have, it might sound strange, just a quick death you know, just get it out of the way you know, rather than be like tortured to death ...	<i>Suicide pact : Description of delusional belief that others would torture them so suicide seemed like a quick death</i>
RESEARCHER	That's what you believed would have happened to you?	
PARTICIPANT 4	Absolutely, absolutely, yeah.	
RESEARCHER	That must have been a really frightening thought?	
PARTICIPANT 4	It was terrifying, it was terrifying. I wasn't so much terrified, believe it or not for myself, I was terrified for my partner... but you know some of the things we were thinking and you know in the month leading up to the pactwe believed we were being followed, we believed there were gangs waiting outside to you know hoist us off the streets and we were under surveillance and the food was tampered with and we were being set up for crimes you know. My partner believed she had things implanted in her body and you know we believed that the people upstairs were listening to us. We were absolutely inundated with paranoias and persecution, delusions and things like that you know. ... and you know what happened as a result of it, was that you know we took the course of action that we did.	<i>Afraid that partner would get hurt</i> <i>Joint delusional belief system leading to suicide attempt</i>
RESEARCHER	Who made the suggestion, who brought it up first?	
PARTICIPANT 4	It was her.	<i>Girlfriend suggested suicide</i>
RESEARCHER	Right.	
PARTICIPANT 4	I remember it all came to a head one morning when we got ourselves in really quite a state you know and she suggested it. My mind recoiled it, I was trying to find some way out of it you know but the more, time progressed, the more that you know we added carriages to those trains...and we kind of like couldn't see a way out of it, so that's why we did what we did.	<i>Recoiled when girlfriend suggested suicide – joint rumination – DSH</i>
RESEARCHER	Yeah. Ok. Um, you've answered lots of these for me already. At some point you had thought about trying to electrocute yourself ...	
PARTICIPANT 4	Mmm.	
RESEARCHER	... and I was thinking that would involve a fair deal of	

planning I would imagine?

PARTICIPANT 4 It did, it did.

RESEARCHER Erm, so the times when you have tried to kill yourself has it generally involved a great deal of planning on your part?

PARTICIPANT 4 Yeah, you definitely have the objective and you kind of work out how to arrive at the objective.

RESEARCHER Right, yeah.

PARTICIPANT 4 You know it's not like you know, you suddenly think I'm going to kill myself that's it. There can be quite a great deal of planning, certainly in my experiences. *Planning involved in DSH*

RESEARCHER Yeah, was planning over a couple of hours or was it planning over days and weeks?

PARTICIPANT 4 Oh no planning over you know, I suppose it was, it was planning over may be 10 minutes ... but it was planning you know ... It was like right I will try this and I will do this and then I'll do this and then this to arrive at this you know To make it happen almost you know? *Planning over 10 minutes*

RESEARCHER Yeah.

PARTICIPANT 4 Erm...I tried to attempt suicide 5 times over the course of 2 days ...

RESEARCHER Was that following your pact with your girlfriend?

PARTICIPANT 4 It was yeah.

RESEARCHER Right.

PARTICIPANT 4 The first time was actually during the pact.

RESEARCHER Right.

PARTICIPANT 4 The other 4 times were immediately afterwards over the course of 2 days.

RESEARCHER Were you by yourself or were you still with your girlfriend?

PARTICIPANT 4 Yeah, I was by myself....and you know with each successive suicide attempt, I don't know the compulsion to succeed diminished you know..... the last 2 attempts, when I tried to electrocute myself, involved stripping down a kettle lead and holding the wires in my hand..... I just didn't have the kind of, I just couldn't get the compulsion up to press the actual switch, thank God. *With each suicide attempt to wish to succeed diminished*

RESEARCHER Was there a part of you that was frightened about what it would be like to electrocuted do you think?

PARTICIPANT 4 I think so, I think so yeah. I think the part of me which was frightened was the part of which said it wouldn't succeed and that's way I didn't try it. *'the part of me which was frightened was the part of which said it wouldn't succeed and that's way I*

didn't try it'

RESEARCHER	Yeah.	
PARTICIPANT 4	I knew that at that point you know, I had to do something or I felt I had to do something quickly and get it right next time or I just wouldn't have the strength in me to carry on.	<i>Urging self on to DSH</i>
RESEARCHER	Yeah.	
PARTICIPANT 4	Do you see what I mean?	
RESEARCHER	Yeah.	
PARTICIPANT 4	The last attempt was the most planned, I really had it in my mind that I was going to do it you know. When that attempt failed, it was just like I didn't have the power, the strength in myself to do it to attempt again after that you know because you know you kind of build yourself up you know to do it and then when you fail you know, you just don't know what to do after that. It's like, with each attempt your kind of strength diminishes you know. You just don't have the will power you know. Because there is a part of you when, when you actually attempting suicide that says "I don't want to do this I really don't want to do this" and you have to fight that to actually attempt itthere's another emotion that says self-preservation and it's strong and you have to fight that to do it	<i>'Build yourself up' to DSH – when fail 'don't know what to do'.</i> <i>After each DSH episode, your strength diminishes, until don't have strength to do it anymore.</i> <i>Have to 'fight' ambivalent thoughts to be able to DSH</i>
RESEARCHER	So there is a part of you, in a sense that sort of acts like a barrier and you have to fight to overcome that barrier?	
PARTICIPANT 4	Yeah it is, absolutely, absolutely, absolutely and it takes a hell of a lot of strength to do it	<i>Need to be strong to DSH</i>
RESEARCHER	I can imagine that you're quite emotionally drained after a failed attempt?	
PARTICIPANT 4	You are, exactly, exactly, that's exactly what you are you know. You feel as if you've been rung out, like a wet tea towel	<i>Feel as though you've been 'rung out like a wet tea towel' after DSH – emotionally drained</i>
RESEARCHER	Yeah.	
PARTICIPANT 4	You know you've just got no strength left in you ...	
RESEARCHER	Is there a sense of being disappointed after the attempts fail?	
PARTICIPANT 4	For me there was yeah, for me there was yeah. ...it was more disappointment because it hadn't succeeded ... I knew that I was getting to the point where I just wouldn't have the strength to attempt again you know and that's why the final attempt was so extreme, there would be no way of failing you know, as I envisioned it anyway. I knew if I failed on that last attempt, then I just wouldn't be able to attempt again because I just didn't have, just didn't have the emotional strength to get past that final barrier you know and that's why so much planning went in to it and why it	<i>Sense of disappointment after suicide attempt fails</i> <i>Imagined that there would be 'no way of failing' as method was 'extreme'</i> <i>Emotional strength to get over barriers ie ambivalent feelings regarding DSH</i>

was so extreme, there would be no way of getting out of it you know..

Suicide attempts 'so extreme' there would be 'no way of getting out of it'

RESEARCHER Yeah..... Ok. It's been suggested that people who self-harm or attempt suicide have difficulties in coping with difficult situations. How do you typically deal with difficult situations?

PARTICIPANT 4 Erm I think it's also based on the personality type you are ... some people are just a lot more buoyant about life than others, you know, secure, they just kind of let difficulties and failures and whatever just bounce off them. They just pick themselves up very quickly and dust off and move on. Some people are kind of like a lot less secure about life you know, and let things get on top of them you know.

Coping related to personality

RESEARCHER Where do you see yourself? Do you see yourself as a buoyant person or someone ...?

PARTICIPANT 4 Back then I was really quite an un-buoyant person, very insecure about life you know but as you get older, you get a lot more secure about life, more secure about yourself. You know what your position in life is ... you know what you hope to achieve, how you're going to achieve it. You learn that there is certainly a lot more value to life and you begin to respect yourself. You see a lot more worth for yourself and worth in yourself. I suppose as a kid, you're kind of spoon fed this thing that you have to be this and you have to do this and you have to be like this to succeed in life you know and when you don't have those things, you think well I'm not succeeding, I'm a failure. As you get a bit older you kind of realise that those things don't really matter that much, it's how you are as a person that counts. How you are with yourself, you know and as you get older you also develop better ways to cope with things you know, much better ways than when you're a kid.

Was an un-buoyant person, insecure about life. As got older became more secure.

As a kid you are 'spoon fed this thing that you have to be this and you have to do this and you have to be like this to succeed in life you know and when you don't have those things, you think well I'm not succeeding, I'm a failure'

Develop better methods of coping as you get older

RESEARCHER So how do you cope with things now?

Changed tape

RESEARCHER So the question was ...

PARTICIPANT 4 How do I cope with things now?

RESEARCHER Yeah.

PARTICIPANT 4 Erm, I have a great deal of respect for myself. I think I'm a very good person, and I understand myself very well now, and I suppose I don't let things get on top of me well as much as I used to I'm much more realistic about getting what I want out of life and where I stand you know and how I perceive myself you know

Coping skills:

- *'not letting things get on top of me'*

RESEARCHER Yeah. Ok. When something stressful does happen, do you get over it quickly or do you tend to think about it a lot?

PARTICIPANT 4	I suppose, if something stressful does happen you know, I do certainly have a number of coping skills which help me get over it ... In here they're called coping skills, outside they just called the way you are you know. I have my art you know, I have my meditation, I have some excellent ways of coping with things you know.	<i>'In here they're called coping skills, outside they just called the way you'</i> <i>Coping skills:</i> - Art - Meditation
RESEARCHER	When you do have something difficult to deal with, do you worry about what other people will think of you?	
PARTICIPANT 4	Erm ... erm ... to a smaller respect ...	<i>Worries about what others will think of ability to cope</i>
RESEARCHER	I was just thinking, after the first time that you tried to hurt yourself, did it become easier to do it again?	
PARTICIPANT 4	Definitely, with the self-harm in prison, definitely. Yeah.	
RESEARCHER	Yeah.	
PARTICIPANT 4	The first time it was, as I said, it's like an urge ... the times after that it was like almost routine, it was just like dealing with the pressure you know. It was just you know it was incorporated in to me .. it was a very unhelpful (laughter) way of dealing with things you know, it was just routine if I had too much pressure, I'd do this ... It's sad really isn't it really but ...	<i>Became easier to DSH after first episode</i> <i>DSH becomes almost routine if under too much pressure</i>
RESEARCHER	Yeah but at the time it was your way of coping?	
PARTICIPANT 4	Yeah it was.	
RESEARCHER	Without any other skills, then it was what you relied upon?	
PARTICIPANT 4	Yeah (laughter).	
RESEARCHER	Ok. What do you think is most likely to lead to you ever self-harming or attempting suicide again?	
PARTICIPANT 4	I don't think anything would.	
RESEARCHER	Ok.	
PARTICIPANT 4	I'd just feel as if I've totally moved on from the kind of personality I was who, who was doing that ... it was just no way of dealing with things you know, no constructive way of dealing with things anyway you know. There's a lot more constructive ways to deal with things you know.	<i>Not the type of personality to DSH</i>
RESEARCHER	Ok ... can you describe a time when you have been able to stop yourself from hurting yourself?	
PARTICIPANT 4	Erm ... yeah there were times in prison, not initially but later, where I did kind of think "what I'm I doing this for, you know? Just why am I doing this? Is life really this bad that its come to this? There must be some better way to deal with things?"	<i>Self-talk used as a means of stopping DSH</i>

RESEARCHER It wasn't particular events, it was more your internal thoughts and what you were saying to yourself?

PARTICIPANT 4 Yeah, yeah, yeah, it's more, it's more kind of "this is just crazy, what I'm doing this for. This is no way to go about things" You know?

RESEARCHER Yeah.

PARTICIPANT 4 Erm and that'd be ok for one night and then you know a couple of nights later when the pressures built up ...

RESEARCHER What do you think is most likely to stop you from ever hurting yourself again?

PARTICIPANT 4 (Long pause) The personality type I am.

RESEARCHER Hmm.

PARTICIPANT 4 I feel as if I've dealt with it and kind of put it in to order you know.

RESEARCHER Yeah.

RESEARCHER Hmm.

PARTICIPANT 4 You kind of come to that place in your life where you can really see nothing else you know any way out *'can't see any way out'*

RESEARCHER Yeah.

PARTICIPANT 4 It's a terrible place to be ... you absolutely lose all sense of yourself, no self-worth, no self-esteem, it's a terrible place to be you know. *'terrible place to be'*

RESEARCHER Ok. Previous research suggests that people who self-harm or attempt suicide often have a history of childhood trauma, for example parental separation or physical and sexual abuse. I was wondering, is there anything in your background that might have made it more likely that you would try and take your own life?

PARTICIPANT 4 I suppose I did really have quite a turbulent and troubled childhood, which certainly led me on partly to taking drugs. So....yeah. *'turbulent and troubled childhood'*

RESEARCHER Is there anything in particular in your childhood that you could sort of pin point?

PARTICIPANT 4 I certainly didn't have any knowledge of other relatives attempting it or anything like that you know ...

RESEARCHER Right.

PARTICIPANT 4 I'm not sure what you mean.....

RESEARCHER I guess I was trying to ask whether there are any events that happened in your childhood that might have made it more likely that you would attempt suicide or self-harm. You're

	parents didn't divorce when you were younger or anything like that?	
PARTICIPANT 4	They did divorce when I was young, yeah.	<i>Parents divorced</i>
RESEARCHER	Right.	
PARTICIPANT 4	My parents separated when I was 18 months old.	<i>Parents separated 18 months old</i>
RESEARCHER	Right.	
PARTICIPANT 4	Erm... then my Dad had a series of, I suppose, relationships and I then went to live with my grandparents for a short while ...	<i>Dad had a number of relationships</i> <i>Went to live with grandparents</i>
RESEARCHER	Hmm, how old were you then?	
PARTICIPANT 4	When I went to live with my grandparents?	
RESEARCHER	Hmm.	
PARTICIPANT 4	3 years old.	
RESEARCHER	Right.	
PARTICIPANT 4	That was probably for about 6 months. I then went back to live back with my father, and at around the age of 5, my step-mum started having a relationship with my father ...things were I suppose, abusive for a while you know, erm ...	<i>Went to live with grandparents aged 3 for 6 months</i> <i>Father remarried age 5</i> <i>Childhood abuse</i>
RESEARCHER	Can I ask in what the abuse was, was it physical abuse, sexual abuse....?	
PARTICIPANT 4	Physical abuse yeah and there was I suppose emotional abuse you know, there was a great deal of poverty within the family and I kind of got the (laughter) the brunt end of it you know. There was no real kind of support in the family for each other. We were all pretty much all our own entities, there was no real gelling, no kind of emotional support for each other ... so it was a very kind of like, here's a family in a very (laughter) loose sense of the word.	<i>Physical abuse</i> <i>Emotional abuse</i> <i>Poverty</i> <i>No family support</i> <i>'all own entities, there was no real gelling'</i>
RESEARCHER	Did the physical abuse come from your father?	<i>Father physically abused participant</i>
PARTICIPANT 4	Yeah.	
RESEARCHER	Ok.	
PARTICIPANT 4	Yeah. Erm yeah.	
RESEARCHER	Ok. I guess I sort of know the answer to this but I'll ask anyway. Which parent did you feel closest too and why?	<i>Felt closet to father</i>

PARTICIPANT 4	It was my father, I've sort of known him my whole life. As we were growing up my Step-Mum was very young and through our teens was very cold you know, very, very detached from me and my brother.	<i>Step-mother was 'cold' and 'detached'</i>
RESEARCHER	What did you put that down to?	
PARTICIPANT 4	Mainly the poverty that we were in.	<i>Attributed step-mother's behaviour to poverty</i>
RESEARCHER	Hmm.	
PARTICIPANT 4	We didn't really have any real comforts ... so yeah.	
RESEARCHER	Ok. Has anyone else in your family ever self-harmed or attempted suicide?	
PARTICIPANT 4	I believe I had an Uncle who attempted suicide but I wasn't aware of that until I came in here.	<i>Uncle attempted suicide</i>
RESEARCHER	Ok. Ok, just a few more questions to get through, I realise it's been a lot longer than we initially anticipated....	
PARTICIPANT 4	(laughter), that's ok.	
RESEARCHER	We know that more women go to professionals after self-harming or attempting suicide than men. Why do think that is?	
PARTICIPANT 4	(Long pause) Maybe it's because it kind of comes from the 'real men don't cry' kind of attitude you know.	<i>'real men don't cry' attitude.</i>
RESEARCHER	Yeah.	
PARTICIPANT 4	Where the man is, is portrayed as somebody who is strong, a strong figure, who would never let on if he was having problems, you would never know if he self-harmed or ever attempted suicide you know. I suppose I think that is probably the reason you know.	<i>Men portrayed as 'strong' who 'would never let on that he was having problems'</i>
RESEARCHER	Yeah.	
RESEARCHER	What do you think other people think about men have self-harmed or attempted suicide?	
PARTICIPANT 4	I think people are people and every person has their own experiences and their own feelings on the matter. I don't think you can really generalise ...	<i>Can't generalise about experiences of others</i>
RESEARCHER	I think that's fair to say, yeah.	
PARTICIPANT 4	Yeah (laughter).	
RESEARCHER	Do you think that men who self-harm or attempt suicide are seen differently to women who self-harm or attempt suicide?	
PARTICIPANT 4	I think women ... from my experience of this place..... I think they certainly tend to be taken a lot more seriously. Is	<i>Women who DSH are taken 'more seriously'</i>

	that true?	
RESEARCHER	Um, I guess in my experience is that it's not talked about as much amongst men	
PARTICIPANT 4	It's certainly never been discussed with me by professionals here. This is the first time (laugh) really you know, so I suppose that's true, yeah. There's a great deal of focus on your mental health problems and the, obviously the offence, the reasons you came here and you know all that, but reasons I self-harmed and attempted suicide, well, it's never been really discussed with me (laugh) ...	<i>Episodes of DSH not discussed by professionals at Rampton, more focus on MH and offences</i>
RESEARCHER	Right.	
PARTICIPANT 4	Yeah, this is the first time really.	<i>'This is the first time' discussed DSH</i>
RESEARCHER	I was actually thinking about treatment but I'll move on to that in a little bit.	
PARTICIPANT 4	Mmm.	
RESEARCHER	Do you think that men and women might self-harm or attempt suicide for different reasons?	
PARTICIPANT 4	No. I think it's their experiences which leads to them to it. I think the reasons as to why, you know, the kind, you know men or women self-harm or attempt suicide are the same.	<i>Believe that men and women engage in DSH for similar reasons</i>
RESEARCHER	Ok. Many people who have self-harmed, have not had help from professionals or haven't found the treatment that they've had, helpful. Have you ever had any professional help for your attempts at suicide or your self-harm?	
PARTICIPANT 4	Never.	<i>Not had any professional help for DSH</i>
RESEARCHER	No. Ok.	
RESEARCHER	What do you think the best way for a professionals to help people who have attempted suicide or self-harm, what do you think are the best approaches?	
PARTICIPANT 4	I suppose in this setting it's very good, you know, your put in such a position where you can't do it, you know. When I first arrived and I was on level 3's, there was some very good nurses and there was one especially who was on most of the time over that 3 months and, we would set up breakfast or you know set up lunch, or do just do little jobs here and there, you know so he could keep an eye on me and he did support me, you know. He talked to me about stuff that I was going through. I think it was a deliberate thing ... but I think it was also a very good way of dealing with it, you know. It was a lot less intrusive than kind of just sitting in a chair, having to one person there and one person there all through the day. There was just one person and we'd do little jobs, doing this and that about the ward. That was much more helpful than kind of being in a chair and being watched.	<i>Rampton useful setting as opportunity to DSH is small</i> <i>Relationship with nurse who would 'do chores' with participant and talked to participant about difficulties was helpful.</i> <i>Being sat in a chair being watched is not helpful</i>

RESEARCHER	Do you think having individual therapy to talk about it, or perhaps a group would have been helpful for you, or is that something that you would have recoiled from?	
PARTICIPANT 4	I think a group would have been something I would have been very anxious about at that point ... yeah a group would have been something which for me at that point, probably wouldn't have been helpful, but definitely somebody on an individual basis coming to talk to me about it. Maybe explain it or just, you know, just explaining the reasons why, you know, why I felt the way I did and why I did what I did, or just offer support or reassurance or something like that would have been really helpful, yeah. Really helpful. Erm but at that point there was none of that really, you know	<i>Would be anxious about group therapy</i> <i>1:1 therapy would be useful</i> <i>Not offered any support regarding DSH</i>
RESEARCHER	So you pretty much coped with it on your own?	
PARTICIPANT 4	Pretty well, yeah, yeah.	
RESEARCHER	What do you think might discourage men from seeking help for their self-harming ?	
Changed Tape		
PARTICIPANT 4	Not wanting to be perceived as some kind of a time waster or someone looking for sympathy or something like that you know.	<i>Fear of being perceived as a "time-waster" or "someone looking for sympathy" may discourage men from seeking help for DSH</i>
RESEARCHER	Yeah. What do you think might encourage men to seek help?	
PARTICIPANT 4	I think it's very good these days, in that there is quite a lot of publicity and stuff about it, you know. When I listen to the radio, erm there's lots of help lines and things like that ... and it's a lot more open these days, you know. People still have the same anxieties about it, especially if it's happening to one of theirs, either relatives or children, or whatever you know.	<i>Media coverage has helped to highlight DSH</i>
RESEARCHER	Hmm, hmm.	
PARTICIPANT 4	But there's certainly a lot more help which is available these days, you know. So I think that's a good thing, you know.	<i>More help available now for DSH</i>
RESEARCHER	Brilliant. Ok. Well that brings us to the end of the interview.	
PARTICIPANT 4	Ok.	
RESEARCHER	If there's anything that you want me to pass on to nursing team, I will.	
PARTICIPANT 4	No, I'm absolutely fine.	

RESEARCHER Are you're sure?

PARTICIPANT 4 Yeah, honestly.

RESEARCHER Brilliant. Ok, well thank you very much.

PARTICIPANT 4 No worries.

APPENDIX K

EXAMPLE OF THEMES DERIVED FROM OPEN CODING FOR INTERVIEW 4

Theme	Exemplar Quotes.
Availability of Means	“when I was in prison, I had a couple of occasions when I did self harm. The availability of objects to self harm with was very easy”
Planning	<p>“There can be quite a great deal of planning, certainly in my experiences”</p> <p>“it was planning over may be 10 minutes ... but it was planning you know ... It was like right I will try this and I will do this and then I’ll do this”</p>
Ruminating	<p>“you become very obsessed in your own thinking”</p> <p>“I remember being in my room, being in a swamp in my mind, with a heavy head, all these worries and anxieties booming through my mind, you know, and not knowing what to do with them”</p> <p>“there was certainly a bit of a lead up where I was getting more and more into my thinking”</p> <p>“you start imagining your self-harming you know and then you can’t get the thought out of you mind, it’s almost like an obsessive thing.”</p>
Confused	“Absolute confusion.....persistent confusion”
Difficulty in problem-solving / Hopelessness	<p>“You kind of come to that place in your life where you can really see nothing else you know any way out....it’s a terrible place to be”</p> <p>“I suppose it was a coping skill for me back then”</p>
Ambivalence	<p>“I did ask myself what I was doing this for. Yeah. I think I did, at the time I thought “what am I doing? What am I doing here? This is crazy”. I think that just added to my confusion”</p> <p>“I was resolute in my mind, but at the same time I was thinking “what am I doing this for?”.</p>
Fighting Ambivalence	“Because there is a part of you when, when you actually attempting suicide that says “I don’t want to do this I really don’t want to do this” and you have to fight that to actually attempt it”
Delusional thinking	<p>“When I attempted suicide both myself and my partner were absolutely inundated with delusions of persecutions and paranoia, to the extent that we believed that we only had like minutes to live ...”</p> <p>“The circumstances were that it was a very persecutory, delusional system, where myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that.”</p>
Relief	<p>“it’s almost like it’s a bit of a relief for my mind”</p> <p>“it did give me a bit of relief from it, because of the way it was kind of a turmoil in my mind, it kind of gave me relief from it for a bit”</p>

Expression of Self-Hatred	“It’s just a weird way of dealing with anger and hatred and self-loathing that I felt. It was a moment of relief for me.”
Addiction	“It [DSH] began with once a week and gradually it was every other day and then, you know, every day. It was getting more frequent and it was getting more severe”
Dyadic Suicide Pact	<p>““myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that.”</p> <p>“in the month leading up to the pactwe believed we were being followed, we believed there were gangs waiting outside to you know hoist us off the streets and we were under surveillance and the food was tampered with and we were being set up for crimes you know. My partner believed she had things implanted in her body and you know we believed that the people upstairs were listening to us. We were absolutely inundated with paranoias and persecution, delusions and things like that”</p>

APPENDIX L

EXAMPLE OF AXIAL CODING FROM INTERVIEW 4

Core Category	Theme	Exemplar Quotes.
Availability of Means		“when I was in prison, I had a couple of occasions when I did self harm. The availability of objects to self harm with was very easy”
	Planning	<p>“There can be quite a great deal of planning, certainly in my experiences”</p> <p>“it was planning over may be 10 minutes ... but it was planning you know ... It was like right I will try this and I will do this and then I’ll do this”</p>
Ruminating		<p>“you become very obsessed in your own thinking”</p> <p>“I remember being in my room, being in a swamp in my mind, with a heavy head, all these worries and anxieties booming through my mind, you know, and not knowing what to do with them”</p> <p>“there was certainly a bit of a lead up where I was getting more and more into my thinking”</p> <p>“you start imagining your self-harming you know and then you can’t get the thought out of you mind, it’s almost like an obsessive thing.”</p>
	Confused	“Absolute confusion.....persistent confusion”
	Difficulty in problem-solving / Hopelessness	<p>“You kind of come to that place in your life where you can really see nothing else you know any way out....it’s a terrible place to be”</p> <p>“I suppose it was a coping skill for me back then”</p>
	Ambivalence	<p>“I did ask myself what I was doing this for. Yeah. I think I did, at the time I thought “what am I doing? What am I doing here? This is crazy”. I think that just added to my confusion”</p> <p>“I was resolute in my mind, but at the same time I was thinking “what am I doing this for?”.</p>
	Fighting Ambivalence	“Because there is a part of you when, when you actually attempting suicide that says “I don’t want to do this I really don’t want to do this” and you have to fight that to actually attempt it”

DSH in direct response to positive Symptoms of Mental Health Problems	Delusional thinking	<p>“When I attempted suicide both myself and my partner were absolutely inundated with delusions of persecutions and paranoia, to the extent that we believed that we only had like minutes to live ...”</p> <p>“The circumstances were that it was a very persecutory, delusional system, where myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that.”</p>
Relief		<p>“it’s almost like it’s a bit of a relief for my mind”</p> <p>“it did give me a bit of relief from it, because of the way it was kind of a turmoil in my mind, it kind of gave me relief from it for a bit”</p> <p>“There was certainly a sense of relief”</p>
	Expression of Self-Hatred	“It’s just a weird way of dealing with anger and hatred and self-loathing that I felt. It was a moment of relief for me.”
	Addiction	“It [DSH] began with once a week and gradually it was every other day and then, you know, every day. It was getting more frequent and it was getting more severe”
Dyadic Suicide Pact		<p>““myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that.”</p> <p>“in the month leading up to the pactwe believed we were being followed, we believed there were gangs waiting outside to you know hoist us off the streets and we were under surveillance and the food was tampered with and we were being set up for crimes you know. My partner believed she had things implanted in her body and you know we believed that the people upstairs were listening to us. We were absolutely inundated with paranoias and persecution, delusions and things like that”</p>

APPENDIX M

EXAMPLE OF A MEMO FROM INTERVIEW 4

Date: 12th August 2007

Title: Properties of Ruminating Process

The participant described a cognitive component in the lead up to episodes of DSH. This consisted of ruminating upon issues, such as delusional persecutory beliefs and the act of self-harming. The participant described an “obsessive” quality to the ruminating process and not being able to see another way out of his problems

Ambivalence was a property of the ruminating process which compounded confusion and difficulties in problem-solving – therefore DSH is an exit from rumination and in this sense provides the individual with relief. Exiting the ruminating process via acts of DSH is a difficult task requiring ‘strength’ and the participant had to ‘fight ambivalence’ in order to self-harm.

Huband and Tantam (2004) found a pathway in which rumination and relief were associated.

Questions to further develop theory:

- What are participants ruminating upon prior to DSH?
- Is rumination present prior to all acts of DSH for all participants?
- Is there always a cognitive component prior to DSH?
- Does rumination consist of thinking about ways out of present difficulties?
- Is the ruminating process similar to the ‘pressure’ described by other participants, with ‘relief’ and ‘release’ describing the same phenomena?

APPENDIX N

EXTENDED RESULTS

Characteristics of Sample:

The sample was comprised of seven men, aged between 24 and 44 years ($M = 35.6$ years $SD = 5.9$). With respect to ethnicity, five participants were White-British; one Afro-Caribbean; and one mixed race Black and White. All participants were single. All 7 participants were detained under MHA (1983) classification for a Mental Illness and had received a diagnosis of schizophrenia (the nosological system employed by clinicians to reach this diagnosis was unclear from the file review). Four were held under Section 47/49 and 3 under Section 37/41 of the MHA (1983). All seven participants had committed an index offence of a violent nature; four had committed murder. None of the participants had committed a sexual offence. Table 4 shows demographic data collected from case file reviews

Table 5 shows participants' first and lifetime episodes of DSH in terms of onset, frequency and method. Age at first DSH episode ranged from 11 to 27 years ($M = 17.4$, $SD = 4.59$ years). Five participants had employed cutting during their first episode; one had overdosed using prescribed medication and one had attempted hanging. The length of time since participants last episode ranged from 2 years to 10 years ($M = 6.3$, $SD = 2.91$ years). All participants described themselves as infrequent self-harmers who had less than one episode of DSH per month. The number of life-time episodes ranged from 5 to 60 ($M = 13.3$, $SD = 19.08$).

Table 4 - Participant demographic information

Participant No.	Age	Ethnicity	Diagnosis	MHA Classification	MHA Section	Index Offence
1	44	White	Schizophrenia	MI	37/41	Violent
2	39	Afro-Caribbean	Schizophrenia	MI	47/49	Violent
3	39	White	Schizophrenia	MI	47/49	Violent
4	24	White	Schizophrenia	MI	47/49	Violent
5	33	White	Schizophrenia	MI	37/41	Violent
6	37	Mixed – Black & White	Schizophrenia	MI	37/41	Violent
7	33	White	Schizophrenia	MI	47/49	Violent

All seven participants had employed cutting as a means of DSH at some point. All participants had employed multiple methods of DSH over the course of their life; six participants had overdosed, three using prescribed medication; four had attempted hanging; two had jumped, (one under a train and the other off of a bridge); one engaged in head-banging; one stabbed himself in the chest; one attempted drowning, one attempted to electrocute himself; one had burnt himself using a lighter; one had gouged out his eye and one had self-circumcised.

Table 5 - Information regarding participants' first and lifetime episodes of DSH in terms of onset, frequency and method.

Participant No.	First Episode of DSH		Life-time Episodes of DSH			
	Age	Method	No. of lifetime episodes	Length of time since last DSH	Frequency of DSH	Methods of DSH
1	18	Overdose	6	5 years	Less than once per month	Cutting Prescribed Meds Jumping
2	19	Cutting	5	7 years	Less than once per month	Cutting Prescribed Meds Jumping Hanging
3	11	Cutting	60	3 years	Less than once per month	Cutting Prescribed Meds Hanging Head-banging
4	15	Cutting	5	7 years	Less than once per month	Cutting Prescribed Meds Stabbing self Drowning Electrocution
5	15	Hanging	7	2 years	Less than once per month	Cutting Overdosing Hanging Burning Self
6	17	Cutting	5	10 years	Less than once per month	Cutting Overdosing Hanging Gouged out eye
7	27	Cutting	5	10 years	Less than once per month	Cutting Circumcised Self

Pathways to Typical Episodes of DSH:

As reported within the article, open and axial coding analysis generated 5 core categories and 12 associated experiential themes. Table 6 provides additional example quotes from transcripts to those provided in Table 1 of the paper, in order to provide the reader with further information regarding the properties and dimensions of the core categories and themes derived from the interviews.

The most common core category in relation to typical episodes of DSH was the availability of means to self-harm (n=7), followed by ruminating (n=6) and DSH as a direct response to positive symptoms of mental health problems (n=5).

Table 6 - Themes derived from participants' subjective experience of typical episodes of DSH.

Core Category	Theme	Exemplar Quotes.
Availability of Means (n=7) (1,2,3,4,5,6,7)		<p>“it’s having the means to do it, to self harm” (participant 2)</p> <p>“when I was in prison, I had a couple of occasions when I did self harm. The availability of objects to self harm with was very easy” (participant 4)</p>
	Planning (n=4) (2,4,6,7)	<p>“I might not be able to do it straight away so I have to plan it and sort of organise it so that I can do it when I’m ready” (participant 2)</p> <p>“There can be quite a great deal of planning, certainly in my experiences” (participant 4)</p> <p>“it was planning over may be 10 minutes ... but it was planning you know ... It was like right I will try this and I will do this and then I’ll do this” (participant 4)</p> <p>“Could be planning for a day, could be planning 5 weeks, sometimes 2 months” (participant 6)</p> <p>“[Planning can last]‘as long as you want” (participant 7)</p>
	Impulsive (n=3) (1,3,5)	<p>“I think each time has been sort of on the spur of the moment you know, so I’ve not really given it a lot of thought” (participant 1)</p> <p>“sometimes it’s like impulsive” (participant 5)</p>

Table 6 - Themes derived from participants' subjective experience of typical episodes of DSH continued

Core Category	Theme	Exemplar Quotes.
Ruminating (n=6) (1,2,3,4,5,6)		<p>"I think to myself, 'I've got nothing to live for, what have I got to live for, I don't know what I've got to live for. Who'd be bothered if I was dead or not'. You think about who'd be bothered if I was dead sort of thing. So at the time you're thinking 'I'd be better off dead'" (participant 1)</p>
	On Past and present difficulties (n=2) (3,5)	<p>"my mind's working overtime....how the family is, or how life was, what I used to have, what I didn't have, what I should have had and what I could have had and to what I've got then I do it." (participant 3)</p> <p>"I'd be thinking of something that's making me unhappy and then I'll do it" (participant 5)</p>
	Confused (n=2) (4,6)	<p>"Absolute confusion.....persistent confusion" (participant 4)</p> <p>"Feeling very confused" (participant 6)</p>
	Difficulty in problem-solving / Hopelessness (n=2) (3,4,5)	<p>"When I've wanted to kill myself, that's when I've had no hope left. That's when I've cried through a lot of it and that's when I've thought well I can't see no end to the problem." (participant 3)</p> <p>"You kind of come to that place in your life where you can really see nothing else you know any way out....it's a terrible place to be" (participant 4)</p> <p>"I suppose it was a coping skill for me back then" (participant 4)</p> <p>"realising that nothing's going to get better" (participant 5)</p>
	Ambivalence (n=3) (2,4,5)	<p>"I questioned myself if I had a good reason to die" (participant 2)</p> <p>"I did kind of think "what I'm I doing this for, you know? Just why am I doing this? Is life really this bad that it's come to this? There must be some better way to deal with things?" (participant 4)</p>
	Fighting Ambivalence (n=2) (4,5)	<p>"Because there is a part of you when, when you actually attempting suicide that says "I don't want to do this I really don't want to do this" and you have to fight that to actually attempt it" (participant 4)</p> <p>"sometimes you urge yourself on to do it." (participant 5)</p>

Table 6 - Themes derived from participants' subjective experience of typical episodes of DSH continued

Core Category	Theme	Exemplar Quotes.
DSH in direct response to positive Symptoms of Mental Health Problems (n=5) (2,3,4,7)	Delusional thinking (n=3) (2,4,7)	<p>"I started thinking I was here to save the worldI'd taken too much on board. I took on the world's problems and I couldn't succeed because I'd been locked up and I didn't have the ability to go any further. I thought to myself I might as well end it." (participant 2)</p> <p>"The circumstances were that it was a very persecutory, delusional system, where myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that." (participant 4)</p> <p>"I started to get a message from the bible and I had to check it a again and again every fortnight for a while....and it was the same message that told me I had to circumcise myself" (participant 7)</p>
	Hearing Powerful Voices (n=2) (3,7)	<p>"Sometimes the voices are too much for me to control." (participant 3)</p> <p>"The voices that made it difficult for me to sleep that night and kept saying things like 'Just end it all'...and 'put a window through', you know, "get some glass" and you know, "end it""(participant 7)</p>
	Resisting the Voices (n=2) (3,7)	<p>"Tell them [the voices] to 'fuck off' and I try to get rid of them, but they won't leave me alone" (participant 3)</p> <p>"[The voices] told me to put a plate through the window. They just kept on and onand I argued with them saying like "You know I can't do that really". That went on for quite a while... I finally did it" (participant 7)</p>
Relief (n=3) (1,3,4)		<p>"It would be a relief at the time, because at the time I was depressed and I was worrying and everything, so it would have been a relief from that at the time." (participant 1)</p> <p>"when I cut myself, all the tension that I've got which is wound up inside of me, I feel it going away. It's like someone's taking a weight off my mind." (participant 3)</p>
	Expression of Self-Hatred (n=3) (3,4)	<p>"It's just a weird way of dealing with anger and hatred and self-loathing that I felt. It was a moment of relief for me." (participant 4)</p>
	Addiction (n=2) (3,4)	<p>"I've been like addicted to the feeling...it brings you back down to your normal way of thinking"; (participant 3)</p> <p>"It [DSH] began with once a week and gradually it was every other day and then, you know, every day. It was getting more frequent and it was getting more severe" (participant 4)</p>

Table 6 - Themes derived from participants' subjective experience of typical episodes of DSH continued

Core Category	Theme	Exemplar Quotes.
Dyadic Suicide Pact (n=2) (1,4)		<p>“me and this girlfriend were both waiting to go to court. We both thought we would get sent down...so without giving it that much thought we both slashed our wrists”; (participant 1)</p> <p>“myself and my partner both believed that we were imminently going to be harmed or worse. So suicide was the best thing to do, we agreed on that.” (participant 4)</p>

Other emergent core categories and themes related to typical episodes of DSH:

In addition to identifying the specific core categories and themes related to pathways to typical episodes of DSH, the open coding process also revealed 8 other core categories with 10 associated themes from the interview data. These core categories and themes were not described in relation to specific episodes of DSH or were found to be present irrespective of pathway experienced and consequently could not be identified and located as components within a particular pathway and so were treated as distinct.

Mounting difficulties (n=7) was the most commonly reported core category, followed by DSH being a private act for individuals (n=6) and a sense of shame and stigma associated with being a person who has self-harmed (n=5). Table 7 summarises these other emergent core categories and themes and provides illustrative quotes.

Table 7 - Other key emergent themes from interviews

Core Category	Theme	Exemplar Quotes.
<p>Mounting difficulties (n=7) (1,2,3,4,5,6,7)</p>		<p>“It’s to do with having too much on my plate, like I’ve had enough Everything’s going against you” (participant 2)</p> <p>“it’s a slow build up. It’s a lot of things all mounting together and I think to myself ‘I can’t take this no more now’ and that’s when I end up doing it” (participant 3)</p> <p>“It was just a gradual building up of pressure you know and self-harm was almost like, pulling the thing on the kettle you know, the whistle” (participant 4)</p> <p>“my life was getting worser and worser by the day and one night I just got a noose” (participant 5)</p> <p>“kind of a slow build-up” (participant 7)</p>
	<p>Interpersonal difficulties with family and friends (2,5,6,7)</p>	<p>“arguments and falling out” (participant 2)</p> <p>“at those particular times I was going through a hard time with them [my family]” (participant 5)</p> <p>“family problems, people arguing, hurt, arguing with sisters, brothers fighting, cousins, this, that and the other like.” (participant 6)</p>
	<p>Engaging in criminal activities (1,2,5)</p>	<p>“I got sent to jail” (participant 1)</p> <p>“I was into criminal activities” (participant 2)</p> <p>“I was thieving all the time, I was in and out of the Police Station” (participant 5)</p>
	<p>“Hanging out with the wrong company” (2,5)</p>	<p>“I was hanging with the wrong company” (participant 2)</p> <p>“My friends were just shoving drugs in us” (participant 5)</p>
	<p>Ending of a romantic relationship (3)</p>	<p>“[My girlfriend] was sleeping with my friends. And when I found out she denied it all and we had arguments and I caught her in bed with one of me friends and in the end I said well what am I bothering for and I started going on a self destruct mode.” (participant 3)</p>
<p>Private Act (n=6) (1, 2, 3, 4, 5, 7)</p>		<p>“hardly any of my friends know about it, my family they don’t even know.” (participant 1)</p> <p>“I’ve always done it in private, I think it’s very private, it’s something that you do on your own, you don’t have people there watching you. It’s not for show” (participant 3)</p> <p>“The first time I wanted people to notice that something was wrong but after that I didn’t want the attention that came with it.....It’s more a private thing” (participant 4)</p>

Table 7 - Other key emergent themes from interviews continued

Core Category	Theme	Exemplar Quotes.
Shame and Stigma (n=5) (1, 2, 3, 4, 6)		<p>“I’d be embarrassed to admit that I’d tried to commit suicide” (participant 1)</p> <p>“Well it’s this scar on my arm and it looks like I’m a suicide victim or something like that, you know, somebody who can’t cope because they had to cut. When you see people with cuts all over their bodies and that, you think “why do they do things like that, it’s like they can’t cope, and that’s why they do it” (participant 2)</p> <p>“I’ve got scars on my arms, and some friends, they didn’t want you to go anywhere with them if you were wearing a short-sleeved top..... I used to be very ashamed so I used to wear long sleeves..... I spent a lot of years in long-sleeved tops in the middle of summer, sweating.” (participant 3)</p> <p>“in prison I was self-harming on my chest, so people couldn’t see” (participant 4)</p>
	Men who self-harm seen as weak (n=4) (1, 2, 3)	<p>“[Referring to men who DSH] I suppose there’s some people who’d just say ‘you’re soft, you’re weak’, you know, I suppose there will be people like that who would just fob it off like that without even wanting to know the reasons why”(participant 1)</p> <p>“men are supposed to be stronger, not as sensitive” (participant 2)</p> <p>“Men are seen as big enough to look after themselves. That’s why a lot of the time I’ve done it and I haven’t asked for help. I’ve just got on with it” (participant 3)</p> <p>“[A man] would never let on if he was having problems, you would never know if he self-harmed or ever attempted suicide” (participant 4)</p>
	Others not understanding (n=4) (1, 2, 4, 5)	<p>“I don’t think [my girlfriend] really understood what was going on in my head but I don’t think anyone would have. I don’t think I tried to explain it to her either” (participant 1)</p> <p>“They [my friends] didn’t really understand why I’d done it.” (participant 2)</p> <p>“[My family] didn’t really understand what I was going through, they couldn’t quite rationalise it” (participant 4)</p> <p>“ [My friends and family] They wouldn’t understand” (participant 5)</p>
	Being seen as ‘crazy’ (n=3) (2, 3, 4)	<p>“, saw my arm straight away and said “What’ve you done to your arm?” and I said “Nothing” and she said “You’re crazy” (participant 2)</p> <p>“when I were younger and I cut myself a lot of the time I didn’t go home until it was clean and stopped bleeding..... Because I was ashamed of the way they’d treat me. They would say ‘looney tunes is at it again’ which is what they used to call me.” (participant 3)</p>

Table 7 - Other key emergent themes from interviews continued

Core Category	Theme	Exemplar Quotes.
Suicide related to lethality of method (n=4) (1,3,4,6)		<p>“I think the only time I’ve really wanted to die was when I was trying to jump off the bridge” (participant 1)</p> <p>“when I’m not cutting myself too deeply cause I don’t want to die.” (participant 3)</p> <p>“that’s why the final attempt was so extreme, there would be no way of failing” (participant 4)</p> <p>“They are more severe attempts are when you want to die” (participant 6)</p>
Adverse Childhood Events (n=4) (2,3,4,5)	Physical abuse (n=3) (2,3,4)	<p>“[My dad] put the newspaper down and started whipping me, whipping me, whipping me, whipping me, whipping me and I was screaming and screaming and screaming and he picked me up like that [makes gesture to suggest someone being picked up by the collar] and punched me in the face like that [makes punching gesture]” (participant 2)</p> <p>“When I wasn’t doing what [my dad] wanted me to do, he used to come out with a belt and he’d beat us.” (participant 3)</p> <p>“Physical abuse, yeah” (participant 4)</p>
	Sexual abuse (n=2) (3,5)	<p>“Sexual abuse from me dad.... One minute he wants to love me, the next minute he wants to love me too much and you’re confused as a kid” (participant 3)</p> <p>“I was with a couple of mates when I was about 5 or 6 ... some older lads bullied us and made us do things to each other and that was an extremely bad experience, I can remember almost being sick, wrenching because what they were making us do was awful.....(Long pause)..... Er... they took our trousers down and erpushed our penis’ like round each other an’ all that.” (participant 5)</p>
	Maternal abandonment (n=2) (2,3)	<p>“My mum went to [country outside of UK] and she never came back” (participant 2)</p> <p>“I was quite abandoned by my mum. I pretty much brought myself up..... She was there when I wanted her but she wasn’t there at the same time. She wasn’t like a loving mother like some people have. I do love her, don’t get me wrong, but she didn’t care about me the way you’d expect her to” (participant 3)</p>
Substance Misuse (n=4) (2,3,4,5)		<p>“I was on drugs” (participant 2)</p> <p>“On occasions when I’ve cut myself in the past I have been taking drugs” (participant 3)</p> <p>“In prison I was using cannabis ... probably some of those nights did coincide with when I did self-harm.” (participant 4)</p> <p>“I was heavily into drugs and all that” (participant 5)</p>

Table 7 - Other key emergent themes from interviews continued

Core Category	Theme	Exemplar Quotes.
Family History of DSH (n=3) (2,3,4)		“My brother committed suicide as well.” (participant 2) “when I was a child, my dad stuck a knife into his arm” (participant 3) “I had an Uncle who attempted suicide” (participant 4)
Observing / Modelling DSH (n=3) (1, 3, 4)		“I’ve seen other people attempt to self-harm. I’ve seen people cut themselves, I’ve seen people wrap things round their necks” (participant 1) “I’d seen my dad when I was a child, my dad stuck a knife into his arm and pulled it all the way up the length of it, cutting the muscle and all the tendons.” (participant 3) “I think that it was the kind of thing that I’d observed, you know. I suppose to a certain extent you see somebody else doing it and it’s almost like copying behaviour.... it’s because you see it working for them” (participant 4)

Participants reported a slow build-up of mounting difficulties (n=7) such as interpersonal difficulties with family and friends (participants 2, 5, 6 and 7), engaging in criminal activities (participants 1, 2 and 5), hanging out with the wrong company (participants 2 and 5) and the end of a romantic relationship (participant 3) and substance misuse (n=4; participants 2, 3, 4 and 5) as antecedents to typical episodes of DSH.

The act of self-harming was described as private (n=6; participants 1, 2, 3, 4, 5, and 7) and associated with a sense of shame and stigma (n=5; participants 1, 2, 3, 4 and 6). Shame and stigma in relation to participants’ self-harming may stem from men who self-harm being seen as weak (participants 1, 2 and 3), others not understanding (participants 1, 2, 4 and 5) and being seen as ‘crazy’ (participants 2, 3 and 4). Suicidal intent was described as associated with the lethality of method employed (n=4; participants 1, 3, 4 and 6).

Participants reported a family history of DSH (n=3; participants 2, 3 and 4) and had experiencing adverse childhood events (n=4; 2, 3, 4 and 5) such as sexual abuse (participant 3 and 5), physical abuse (participants 2, 3, 4) and maternal abandonment (participants 2, and 3). Participants also described observing or modelling DSH (n=3; participant 1, 3 and 4) both within institutions (participants 3 and 4) and within the community (participant 1).

Pathways to First Episodes of DSH

The open and axial coding analysis yielded 8 core categories and 16 associated themes in relation to participants' reports of first episode of DSH. These are summarised in Table 8, together with illustrative quotes extracted from transcripts.

Table 8 – Experiential core categories and themes derived from participants’ recollections of their first episode DSH

Core category	Theme	Exemplar quotes
Interpersonal difficulties (n=7) (1,2,3,4,5,6,7)	“Not getting along” with family (n=7) (1,2,3,4,5,6,7)	<p>“I didn’t get along with my dad full stop” (participant 2)</p> <p>“my brother was threatening me, I had the kitchen knife and I said if you come anywhere near me I’ll stab you. I ran outside the house and put the knife to my own wrist.” (participant 3)</p> <p>“My relationship with my family was not good, not good at all” (participant 4)</p>
	“Cast out into the world” (n=3) (2,3,4)	<p>“My dad kicked me out of my parent’s house”(participant 2)</p> <p>“I wasn’t welcome at home. I was better off getting out of the house away from my mum” (participant 3)</p> <p>“At the time I was like 12 and 13 and I decided that enough was enough and I had to go and stand on my own two feet. I mean I’d had pretty much enough of it, you know what I mean, I didn’t really want to be a part of the family any more” (participant 3)</p> <p>“I really felt as if I was cast out in the world by myself, you know” (participant 4)</p> <p>“I was very sensitive and didn’t feel as if I really fit in [the family]” (participant 4)</p>
	“No emotional support in the family” (n=2) (4,5)	<p>“There wasn’t really any support or, I didn’t feel as if there was any emotional content in the family” (participant 4)</p> <p>“They [family] didn’t seem to want to sit me down and say “look we love you” and all that, they just let me get on with it.” (participant 5)</p>
	Ending of a romantic relationship (n=2) (1,2)	<p>“Well, a while before that a girl that I liked or was a girlfriend, so to speak, had finished with me and gone off with somebody else and that was the main cause.” (participant 1)</p> <p>“I also met a girl at a nightclub, went out with her for about a month and thenshe blew me out so I cut her name on my arm first, and then cut my name on my arm second, and I burnt my arm with a cigarette as a full stop at the end” (participant 2)</p>
	Pressure to achieve goals relevant to life-stage (n=2) (3,5)	<p>“Life isn’t going very well, you haven’t done what you needed to do in that period of your life” (participant 3)</p> <p>“My family kept on going on about jobs and that. I’d say to them “I’m trying to get a job but I just can’t”, you know and they said “ah, if you wanted to get a job, you could get a job” but I couldn’t..... Me Dad was the kind of person like where he thinks that everyone should make a life for themselves and I wasn’t doing that, so he didn’t like it...But the worst thing about it, me family and people around me didn’t realise that I was having a hard time of it and they said I was bringing this all on me self, and that was just pissing me off even more, because I was trying” (participant 5)</p>

Table 8 – Experiential core categories and themes derived from participants’ recollections of their first episode DSH continued

Core category	Theme	Exemplar quotes
Depressed (n=6) (1,2,3,4,5,6)		<p>“I wasn’t eating very well, I’d lost a lot of weight, I was depressed” (participant 1)</p> <p>“I think I was a bit depressed to be honest.” (participant 4)</p> <p>“I was just really depressed” (participant 5)</p>
	“Down in the dumps” (n=3) (2,3,6)	<p>“pretty down in the dumps” (participant 2)</p> <p>“feeling down in the dumps” (participant 3)</p> <p>“Well I was just feeling pretty low in my life and upset and that, so I thought you know, end it all.” (participant 6)</p>
Rumination (n=6) (1, 2,3,4,5,6)		<p>“you kind of shut yourself away from things that potentially hurt you and you become very obsessed in your own thinking, kind of brooding” (participant 4)</p>
	On past and present difficulties (n=1) (2)	<p>“thinking about why my mum had gone, my dad’s kicked me out, not seeing my sisters that often” (participant 2)</p>
	Confused (n=3) (3,4,6)	<p>“I was more confused than anything else.” (participant 3)</p> <p>“I was really quite stressed at the way things had turned out in my life and very confused with life and, very down with life as well” (participant 4)</p> <p>“I was a very confused, very mixed up teenager, who really was in a quagmire in his mind at that time, you know. I literally felt I was kind of suffocating with it. I didn’t understand life, what it was about, where I was going” (participant 4)</p> <p>“Pretty confused about life” (participant 6)</p>
	Being unsure of direction to take in life (n=2) (3,4)	<p>“I didn’t know what I was supposed to be doing any more, so I thought well I’m better off just ending it and getting it over and done with” (participant 3)</p> <p>“I think there was a lot of pressure at school, I think there was exams coming up. I was in my final year, so really people were starting to be streamed into the various things that they were doing, and I didn’t really know what I wanted to do. So there was a lot of pressure on you to make those choices and decisions about your life, I really didn’t have much clue about what I wanted” (participant 4)</p> <p>“You kind of got used to school for the best part of 10 years, you know, and then you’re going to be kicked out and the rest was up to you……. I just felt totally unprepared. I had people at school and they were doing this or doing that and I was by myself doing nothing” (participant 4)</p>

Table 8 – Experiential core categories and themes derived from participants’ recollections of their first episode DSH continued

Core category	Theme	Exemplar quotes
	Difficulty in problem-solving / Hopelessness (n=2) (1, 4)	<p>“I felt that nobody could help me, I felt that the only way to deal with it was to kill myself” (participant 1)</p> <p>“Anticipating things that might not really happen” (participant 1)</p> <p>“It was more it was a bit of a prison I’d got myself into in my own mind, I couldn’t really see beyond the bars” (participant 4)</p> <p>“I remember being in my room, being in a swamp in my mind, with a heavy head, all these worries and anxieties booming through my mind, you know, and not knowing what to do with them” (participant 4)</p>
	Anticipating relief from DSH (n=3) (1,4,5)	<p>“I always thought that death was just like blackness, just as if you close your eyes and think black, you know, and that’s it. There’s nothing..... I’ve sort of looked forward to that time when it can be like that, and be that total nothing. Everything stops, there’s nothing at all.” (participant 1)</p> <p>“it’s almost like it’s a bit of a relief for my mind” (participant 4)</p> <p>“I was hoping it would be like a release, you know. I’d be set free, you know, away from all of the troubles of the world” (participant 5)</p>
	Ambivalence (n=2) (4,5)	<p>“I did ask myself what I was doing this for. Yeah. I think I did, at the time I thought “what am I doing? What am I doing here? This is crazy”. I think that just added to my confusion”(Participant 4)</p> <p>“I was saying to myself “death is the only way out” but when I was hanging there, I got it in me head it’s got to get better than this” (Participant 5)</p>

Table 8 – Experiential core categories and themes derived from participants’ recollections of their first episode DSH continued

Core category	Theme	Exemplar quotes
Substance Use (n= 5) (1,2,5,6,7)	Alcohol use (n=2) (1,2)	<p>“I was drinking alcohol” (participant 1)</p> <p>“I’d had quite a lot to drink, I was pissed out of my head and I started to cut my name in my arm with a Stanley knife” (participant 2)</p> <p>“Drinking alcohol” (participant 6)</p>
	Drug use (n=3) (5,6,7)	<p>“I was on drugs” (participant 5)</p> <p>“I was heavily into drugs” (participant 6)</p> <p>“Well only about cannabis really” (participant 7)</p>
	Substance misuse to “relieve pain” (n=1) (2)	<p>“At the time I was low, I’d been drinking heavy, I was drinking to like relieve the pain sort of thing.” (participant 2)</p>
	Substance misuse affecting thinking (n=1) (2)	<p>“because I was really pissed I wasn’t really thinking” (participant 2)</p>
Impulsive (n=5) (1,2,3,4,5)		<p>“I didn’t really give it a lot of thought before-hand, just before-hand. It’s just like I saw the tablets on the table” (participant 1)</p> <p>“It was just something I did, you know, spur of the moment” (participant 4)</p> <p>“Pure boredom, there was nothing to do” (participant 5)</p>
Social Isolation (n=4) (1,2,3,4)		<p>“I started to cut myself off and stayed in my bedroom a lot of the time” (participant 1)</p> <p>“No-one to talk to or nothing. No-one out there was going to give me the help that I needed.” (participant 3)</p> <p>“I just didn’t feel as if I was part of anything I suppose. I didn’t feel as if I was part of a family or had friends, or part of school even, I just didn’t feel as if I was a part of anything, so I just felt totally isolated and by myself” (participant 4)</p>

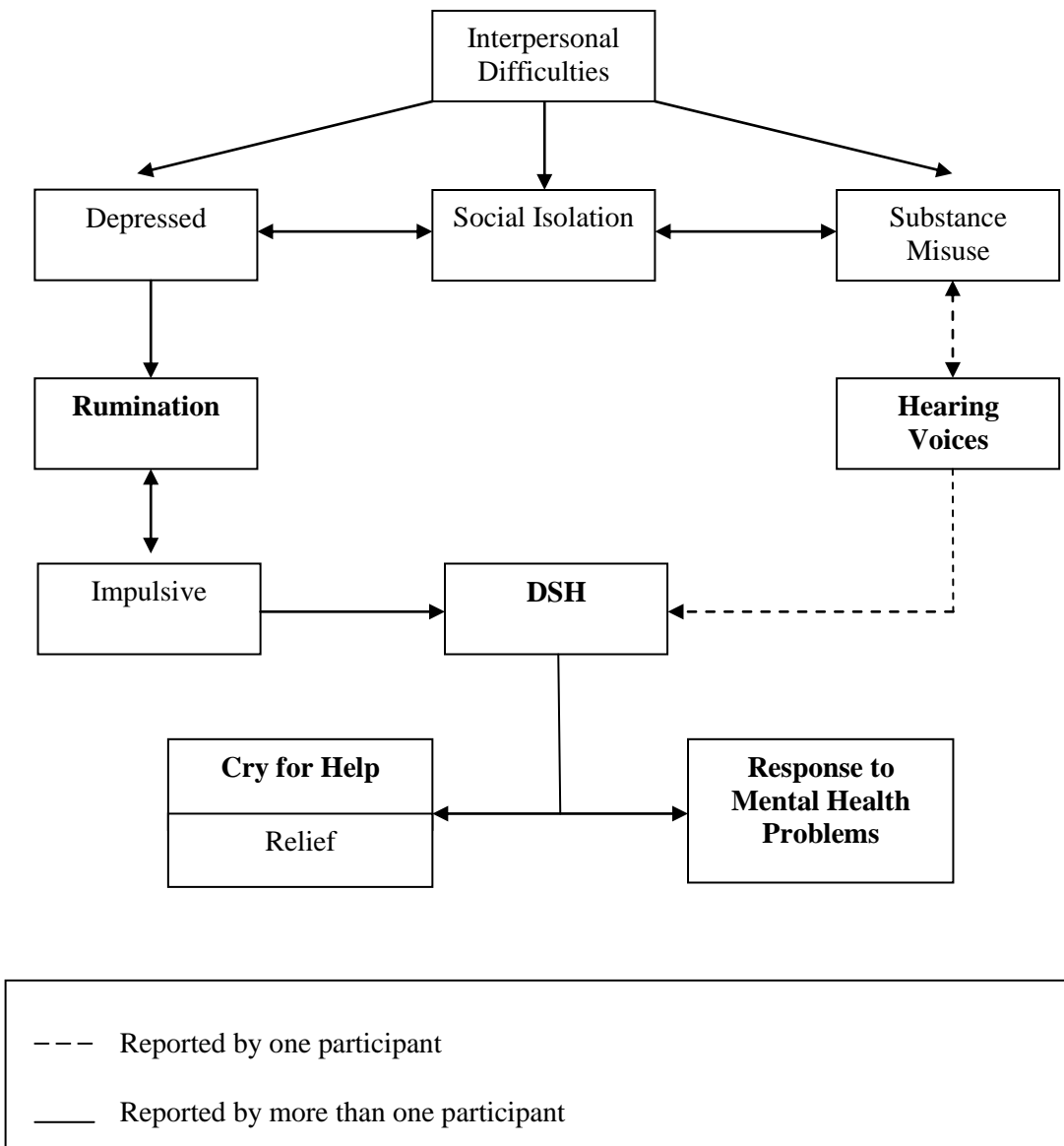
Table 8 – Experiential core categories and themes derived from participants’ recollections of their first episode DSH continued

Core category	Theme	Exemplar quotes
Cry for Help (n=2) (1,4)		<p>“I think it might have been a bit of a cry for help really” (participant 1)</p> <p>“it was definitely a cry for help and that’s what I was thinking just before hand, you know, “if somebody sees this expression of what’s going on in my mind, then surely they’ll talk to me and they’ll ask me what’s going on, they’ll sort of say to me - look what you’re doing, tell me what’s going on”. Nobody did, so, (laughter) you know. I suppose I imagined somebody might take pity on me (laughs), you know show me some attention. I was a very confused lad. But I think that was basically it, yeah, “show me some attention, please!” (participant 4)</p>
Hearing voices (n=1) (7)		<p>“The voices were chronic, really, really terrible the amount of voices. In my head all the time.” (participant 7)</p> <p>“They were saying it to me, egging me on, saying if I didn’t self-harm they would like threaten to hurt 200 people. Threatening all these people.”(participant 7)</p>

The most common core category reported by participants in relation to their first episode of DSH was interpersonal difficulties (n=7) followed by feeling depressed (n=6) and rumination (n=6).

Selective coding allowed for an interpretation of the core categories and themes from the open and axial stages of coding which allowed for theory development. Figure 2 depicts the temporal progression from one theme to another contained within participants’ recollection of their first life-time episode of DSH.

Figure 2 – The temporal progression from one core category to another contained within participants' recollection of their first episode of DSH



First episodes of DSH were characterised by the presence of interpersonal difficulties (n=6) such as the end of a romantic relationship (participants 1 and 2), individuals feeling under pressure to achieve goals relevant to their life-stage (participants 3 and 5), not getting along with family members (participants 1, 2, 3, 4, 5, 6 and 7) and participants felt that were cast out into the world by themselves (participants 2, 3 and 4) as there was little or no emotional support within their family (participants 4 and 5).

These interpersonal difficulties led to individuals feeling socially isolated (n=4; participants 1, 2, 3 and 4), depressed (n=6; participants 1, 2, 3, 4, 5 and 6) and many engaged in substance use (n=5) such as alcohol use (participants 1 and 2) and drug use (participants 5, 6 and 7) in order to relieve pain (participant 2). Substance misuse was noted to affect the individual's thinking (participant 2).

The core categories interpersonal difficulties, social isolation, feeling depressed and substance misuse were not specific to a particular pathway. Two distinct pathways to first episodes of DSH were identified; the Relief Pathway (n=6), consisting of a cry for help function (n=2) and the Response to Mental Health Problems Pathway (n=1), in which the first episode of DSH was directly related to the experience of hearing voices instructing the individual to self-harm. Differentiation between pathways was again related to the presence or absence of positive symptoms of mental health problems. It is important to note that not all of the participants described the function of their DSH, but did report antecedents to their first DSH episode.

The Relief Pathway to first episodes of DSH was defined by individuals ruminating (n=6) upon past and present difficulties (participant 2), being unsure of which direction to take in life (participants 3 and 4) and consequently feeling confused (participants 3, 4 and 6). The ruminating process also involved difficulties in problem-solving and associated hopelessness (participants 3 and 4) and it was anticipated that self-harm would provide a relief (participants 1, 4 and 5). The ruminating process was punctuated by moments of ambivalence (n=2; participants 4 and 5) in which individuals questioned whether to self-harm or not. For those that experienced the Relief Pathway the final decision to engage in DSH was impulsive (n=5; participants 1, 2, 3, 4 and 5)

and functioned as a cry for help (n=2; participants 1 and 4) in which relief was anticipated by calling attention to the individual's distress.

The Response to Mental Health Problems Pathway to first episodes of DSH was described by one participant only and was distinguished by the presence of hearing voices (participant 7). Interpersonal difficulties, such as *"falling out with friends and parents"* led to substance misuse in the form of cannabis. Following this the participant began hearing voices which *"were egging me on, saying if I didn't self-harm they would like threaten to hurt 200 people. Threatening all these people"* and in response to this threat participant 7 cut himself.

Views of DSH-Related Interventions

The open and axial analysis yielded 3 core categories and 4 associated themes regarding participants' views of interventions related to DSH. These are summarised in Table 9, together with illustrative quotes extracted from transcripts. The most commonly reported core category was not having had the opportunity to engage in psychological treatment addressing DSH (n=7).

Table 9 - Key themes related to participants' views of DSH interventions

Core Category	Theme	Exemplar Quotes.
No opportunity to engage in psychological treatment addressing DSH (n=7) (1,2,3,4,5,6,7)		“It’s certainly never been discussed with me by professionals here. This is the first time (laugh) really.....There’s a great deal of focus on your mental health problems and the, obviously the offence, the reasons you came here and you know all that, but reasons I self-harmed and attempted suicide, well, it’s never been really discussed with me” (participant 4)
	Having Someone to talk to as a potentially useful intervention (n=7) (1,2,3,4,5,6,7)	<p>“Just like talk to them, just like you have with me today..... I think that if nobody talks to you about it then there’s more chance of you trying to do it again” (participant 1)</p> <p>“I wanted someone to talk to get it out of me system. You know what I mean, I just wanted someone to talk to.” (participant 3)</p> <p>“Try to see things the things that are important to the people who are harming themselves, help them to think through things for themselves and that.” (participant 6)</p>
	Group therapy (n=6) (1,3,4,5,6,7)	<p>“I think a group would have been something I would have been very anxious about at that point ... yeah a group would have been something which for me at that point, probably wouldn’t have been helpful, but definitely somebody on an individual basis coming to talk to me about it” (participant 4)</p> <p>“I don’t like working in groups, I feel uncomfortable”(participant 6)</p>
Unhelpful Professional Help Experienced (n=3) (3, 4, 5)		“They [nurses] just bandaged me up and told me to get lost” (participant 5)
	Medication (n=2) (3,5)	<p>“It wasn’t the medication I was after, it was I needed someone to talk to and I wasn’t getting that help” (participant 3)</p> <p>“I was talking with the staff yesterday and was saying that I don’t know why I was bothering any more, and the staff said ‘You’ll be OK after the PRN’. It’s not the be all and end all, PRN..... they don’t really want to sit you down and talk to you about it, they just want you to have some PRN” (participant 3)</p> <p>“I went to see the doctor a couple of times and he just put me on tablets, he never talked me or anything, he just put on medication and that’s about it.” (participant 5)</p>
	Close nursing observations (n=1) (4)	“for about the next 4 months I was on Level 3’s which is where you have 1 or sometimes 2 people with you 24 hours a day... at times you kind of resented them, the nurses, because you didn’t wanted to be followed about or you just wanted a bit of space, you know, but it worked, I’m still here today, So, as an actual preventative measure, it worked.” (participant 4)

Table 9 - Key themes related to participants' views of DSH interventions continued

Core Category	Theme	Exemplar Quotes.
Regime at Rampton Hospital Prevented Episodes of DSH (n=3) (2, 3, 4)		“when I was in Rampton Hospital, I tried to take tablets only I didn’t take them, saved them up but they found them” (participant 2) “I haven’t been able to in here but I do like to.” (participant 3) “I suppose in this setting it’s very good, you know, you’re put in such a position where you can’t do it” (participant 4)

None of the seven participants had engaged in psychological treatment specifically for their DSH. Participants described having someone to talk to (n=7; participants 1, 2, 3, 4, 5, 6 and 7) as a useful professional intervention which they would have welcomed, whereas group therapy addressing their DSH was described as an unhelpful professional intervention they would not have entered into (n=6; participants 1, 3, 4, 5, 6 and 7).

Some participants had experienced professional attention for the self-harm (n=3; participants 3, 4 and 5) and described these as unhelpful. Being provided with medication was seen as unhelpful (n=2; participants 3 and 5) as participants were looking for someone to talk to. Close nursing observations were resented (participant 4), but acknowledged as a useful preventative measure which halted further episodes of self-harm. The regime at Rampton high-secure hospital was reported as preventing episodes of DSH (n=3; participants 2, 3 and 4).

APPENDIX O

EXTENDED DISCUSSION

The present study is the first to explore the causal pathways to episodes of self-harm as experienced by mentally ill men currently detained within a high secure hospital and their view of related interventions by interviewing patients directly in an effort to develop a conceptual understanding of DSH within this often ignored population. The only other study to examine self-harming behaviours within this group has focussed solely on prevalence rates and methods of self-harm using information gleaned from nursing case notes (Jackson, 2000). The findings of this study indicate a two-pathway aetiology of DSH among mentally ill men within a high secure hospital setting; the Relief Pathway and the Response to Mental Health Problems Pathway. These pathways were present for both first and typical episodes of DSH and consequently will be discussed in combination. The following section will describe supporting and contradictory evidence for these emergent pathways and other findings within this study from the existing literature. The clinical implications of the findings, the limitations of the present study and directions for further research will also be explored.

Within this study, many individuals who experienced episodes of DSH related to the Relief Pathway also experienced episodes which followed the Response to Mental Health Problems Pathway. Therefore, those who repetitively self-harm may experience episodes of DSH related to either pathway over the course of their life. Consequently, it is essential that clinicians carefully assess the typical pathway which leads to episodes of self-harm for individuals in order to specifically target components within the pathway for change.

The Relief Pathway

The Relief Pathway was characterised by individuals ruminating upon difficulties within their lives both past and present, being unsure of which direction to take and subsequently being unable to see a way out of these problems. Confusion and hopelessness regarding their situation also formed part of the ruminating process. The act of self-harm was anticipated to provide a sense of relief for individuals. The decision to engage in DSH was fraught with ambivalent feelings which individuals had to fight in order to be able to self-harm. The final decision was often impulsive and aided by the availability of means to be able to self-harm. Therefore, DSH within the Relief Pathway can be conceptualised as a maladaptive problem-solving strategy (Haines & Williams, 1997) whose genesis lies in a dysfunctional cognitive style. The Relief Pathway consisted of three inter-related functions; relief, a cry for help and an expression of self-hatred. A single episode of DSH was found to serve multiple functions for some individuals. Therefore, treatment may need to target the earlier cognitive components of this pathway rather than the aiming to change the function of the individuals' DSH.

The ruminating process within the Relief Pathway involved other cognitive factors, such as poor-problem solving and hopelessness. Like earlier studies, the present findings suggest that cognitive factors may play a critical role in the lead up to episodes of DSH (Williams & Pollock, 2000; Williams et al, 2000; Haines & Williams, 1997; Jollant et al, 2005; Neuringer & Lettieri, 1971; Linehan et al, 1987; Orbach et al, 1990; Walsh & Rosen, 1988; Neuringer, 1961; Neuringer, 1967; Neuringer, 1968). Neuringer (1976) maintained that when individuals who self-harm experience difficulties, they

struggle to modulate their expectancies or contemplate compromise and consequently view their environment as offering few opportunities for change or relief. The findings of the present study lend support to this view. Many previous studies concerned with the cognitive processes of those who self-harm have been criticised as being based on artificial and impersonal problem-solving tasks, such as word finding and map-reading and it argued that interpersonal problem-solving within everyday life may constitute an inherently different process (Schotte & Clum, 1982; Arffa, 1983). However, the present study suggests that those who engage in DSH may experience difficulties in problem-solving within their everyday life prior to episodes of DSH.

Poor problem-solving skills were highlighted within this study as a cognitive factor involved in the ruminating process experienced by mentally ill men prior to episodes of self-harm. Deficits in problem-solving ability have been well recognised as a psychological characteristic of those who self-harm by other studies (Williams & Pollock, 2000; Williams et al, 2000; Haines & Williams, 1997) and psychological treatment addressing DSH has aimed to enhance problem-solving skills in those diagnosed with borderline personality disorder (Linehan, 1993). Several studies comparing individuals who self-harm with controls have found important qualitative differences in problem-solving skills. Levenson and Neuringer (1971) examined the relationship between problem-solving and DSH. Their results indicated that people who self-harm were less able to adapt their problem-solving strategies. Another study which investigated problem-solving among inpatient suicide attempters, suicidal ideators and non-suicidal psychiatric inpatients found that suicide attempters were more passive in their problem-solving than the other groups and with a tendency to let problems solve themselves or rely on others for solutions (Linehan et al, 1987).

Similarly, Orbach et al, (1990) found that patients who had self-harmed were more passive (tending to rely on others), less versatile and less relevant in the solutions they supplied for problems. Mirroring these findings, the present study suggests that mentally ill men who self-harm struggle to generate relevant solutions to difficulties they encounter and consequently use DSH as a means of problem-solving. This suggests that for mentally ill men who experience episodes of DSH along the Relief Pathway, treatment which enhances the individuals' problem-solving ability may be therapeutically beneficial.

Hopelessness was found to be associated with the ruminating process within this study and was felt in relation to the mounting difficulties experienced by individuals prior to an episode of DSH. Until relatively recently there has been a paucity of research exploring the concept of hopelessness. Abramson et al (1989) discuss hopelessness in terms of an expectancy that negative consequences will occur rather than positive. Hence, future directed thinking has been implicated as a risk factor for DSH (MacLeod et al, 2004). Previous research into self-harming behaviours has implicated hopelessness and a lack of future directed thinking as a proximal antecedent for DSH. MacLeod et al (1993) conducted a study to examine the role of future-directed thinking in DSH. They found that relative to the other groups, individuals who had had a recent episode of DSH showed difficulties in future-directed thinking. This effect was present for both immediate and long-term future events. Furthermore, Rudd et al (1994) suggest that suicidal ideators tend to focus on potentially negative consequences of implementing alternative problem-solving strategies and Dixon et al (1994) concluded that hopelessness mediates the relationship between problem-solving and suicidal ideation. The present study adds evidence to support these studies. It has been

suggested that individuals who self-harm do so because they lack the behavioural repertoire to cope with problem situations (Walsh & Rosen, 1988) and this may be the case for mentally ill men who experience the Relief Pathway.

The decision to self-harm was often impulsive within the Relief Pathway and the availability of means to engage in DSH was sufficient to trigger an episode of DSH. This is similar to other research which suggests that over 50% of those that self-harm did not think of it for more than one hour prior to the episode (Williams, 1997). Impulsivity and the presence of available means to self-harm assisted in overcoming ambivalence regarding whether or not to self-harm for individuals experiencing the Relief Pathway. Research suggests that limiting the availability of means to self-harm leads to a reduction in DSH. In the year following legislation to reduce pack sizes for analgesics in the UK, the incidence rate of paracetamol overdoses dropped (Turvill et al, 2000; Hawton, 2004b), especially rates of severe overdoses (Turvill et al, 2000). Therefore, the findings of the current study suggests that reducing the availability of methods of self-harm would be a useful preventative measure for mentally ill men who self-harm and is likely to lead to a reduction in impulsive acts of DSH, particularly for those who experience the Relief Pathway to episodes of self-harm. However, it is important to note that when means to self-harm were unavailable, the men within this study described planning episodes of DSH. This planning could be brief, lasting 10 minutes or could occur over the course of a couple of months.

Within the Relief Pathway, episodes of DSH functioned primarily as a means of gaining relief from interpersonal difficulties or aversive events encountered for individuals and this relief was anticipated within the ruminating process. The relief

function closely resembles the affect-regulation model, described by previous researchers, in which DSH alleviates acute negative affect or aversive arousal (Klonsky, 2007; Brown et al, 2002; Shearer, 1994; Herpetz, 1995; Osuch et al 1999; Briere & Gil, 1998; Brian et al, 1998). However, unlike the affect-regulation model, individuals who reported experiencing the Relief Pathway did not associate DSH with sense of relief from negative affective states or physiological arousal, but rather they reported gaining relief from rumination, distressing cognitions or difficult life situations. A number of studies suggesting a relief or affect-regulation function of DSH have focussed solely on women or had an overrepresentation of women within their sample (Brown et al, 2002; Shearer, 1994). Therefore, the present finding that DSH provides a relief from cognitive factors may be a reflection of differences in the manner in which men communicate distress (Danielsson & Johansson, 2005) or provide an indication that cognitive processes are more pertinent in male DSH than in their female counterparts. This is clearly an area in need of further dedicated research.

Gaining relief from DSH was found to have an addictive quality within this study. This may be owing to this maladaptive problem-solving strategy being positively reinforced by its consequences and so DSH becomes the preferred choice of coping for some individuals within the Relief Pathway. Increasing frequency and severity of DSH episodes was reported in association with the addictive quality of the Relief Pathway within the present study. This finding lends credence to Skegg's (2005) proposal that an affect-regulating or relief function of DSH may contribute to a propensity for self-harming to become repetitive and Carter et al's (2005) findings in which increasing levels of severity were present in successive episodes of DSH. Therefore, individuals

who experience the Relief Pathway may be more prone to repetitive acts of DSH which become increasingly severe overtime.

For some individuals who experience the Relief Pathway, the findings suggests that DSH may also serve a secondary function of a cry for help and a means of calling attention to distress. The cry for help function of the Relief Pathway closely maps onto the interpersonal-influence model of DSH (Klonsky, 2007), in which self-harm acts as a means of seeking help from or manipulating others (Allen, 1969; Bachman, 1972; Allen 1995; Brown et al, 2002; Briere & Gil, 1998; Herpetz, 1995; Shearer, 1994). The cry for help function was only reported within first episodes of DSH, with later episodes of DSH not serving this purpose. Therefore, it is possible that first episodes of DSH are concerned with calling attention to distress and difficulties encountered by the individual, with later episodes becoming a private act in which attention is unwanted owing to the stigma and shame associated with acts of DSH. This finding, in addition to increasing frequency and severity of episodes of DSH, indicates that the function of self-harm may evolve overtime for mentally ill men and this is an area in need of further investigation.

In addition to DSH functioning as a relief and a cry for help, episodes of self-harm following the Relief Pathway may also serve the secondary function of an expression of self-hatred. The expression of self-hatred function is closely aligned with the self-punishment model (Klonsky, 2007) in which DSH represents an expression of anger towards oneself (Herpetz et al, 1997; Soloff et al, 1994; Klonsky et al 2003; Shearer, 1994; Brown et al, 2002; Briere & Gil, 1998; Herpetz, 1995; Nock & Prinstein, 2004; Osuch et al 1999; Kumar et al, 2004). Empirical support for a self-punishment or expression of self-hatred function of DSH has been inconsistent, with this function

appearing to be a prominent motivation for DSH in some studies but not in others (Klonsky, 2007). It has been suggested that self-punishment may be a secondary reason for episodes of DSH, with affect-regulation being the primary reason (Klonsky, 2007), findings from the present study add credence to this view and indicates that self-punishment may be a secondary function of the Relief Pathway and is associated with gaining a sense of relief from the act of self-harming.

The Relief Pathway identified within this study closely maps onto Huband and Tantum's (2004) 'Spring Pathway' which they described with reference to repeated self-wounding in women admitted to a general psychiatric hospital. Huband and Tantam's (2004) 'Spring Pathway' consisted of rumination, periods in which individuals struggled between cutting and not cutting, the presence of an effort to resist cutting and cutting providing a relief; these factors are similar to the ruminating process, ambivalence, fighting ambivalence and relief components of the Relief Pathway. It is, therefore possible that the Relief Pathway is a core pathway to episodes of DSH irrespective of gender or psychiatric diagnosis.

The Response to Mental Health Problems Pathway

The Response to Mental Health Problems Pathway was characterised by the presence of positive symptoms of mental health problems, such as hearing powerful voices instructing the individual to self-harm or delusional thinking in which DSH seemed to be a logical decision in light of the individuals' belief that they were being persecuted, that the world had ended or that the bible favoured this course of action. For those that experienced auditory command hallucinations, there was an attempt to resist the voices by arguing with them. However, the voices were experienced as more powerful than

the individual and so eventually the individual acquiesced to the command to self-harm in order to appease the voices. Again, the availability of means to self-harm directly led to episodes of DSH within this pathway.

DSH as a response to active symptoms of mental health problems, such as auditory command hallucinations and delusions has received relatively little attention within the current evidence-base. Indeed, it was not even acknowledged in a recent review of the functions of DSH (Klonsky, 2007). This may be owing to researchers exploring DSH as a behavioural phenomena often focussing on those with a diagnosis of borderline personality disorder (Shaw, 2002). Findings from this study highlight positive symptoms of schizophrenia, such as delusions and auditory hallucinations as factors which directly influence self-harming behaviours for mentally ill men. Therefore, treatment needs to address positive symptoms of mental health problems for men who experience this pathway to episodes of self-harm. Previous research exploring the relationship between positive mental health symptoms and DSH have revealed inconsistent results (Hawton et al, 2005; Fenton et al, 1997; Grunebaum et al, 2001; Heila et al, 1997; Roy 1982; Cantor et al, 1989).

A history of DSH has been reported in those who experience auditory command hallucinations within some studies (Simms et al, 2007; Lee et al, 2004) and the present findings appear to support this. Hearing voices which influenced self-harming was only reported by one participant in relation to their first episode of DSH; hence, this pathway may be more common in later episodes of self-harm. Although those who experienced auditory command hallucinations to self-harm attempted to resist the voices, a factor found within previous research (Simms et al, 2007), their belief about

the power held by the voices resulted in them complying with instructions to self-harm. Resisting voices which are experienced as malevolent has been found within previous research (Sayer et al, 2000) and it has been suggested that treatment may need to address the individuals' belief about the power held by the hallucinations (Chadwick et al, 1996). Interestingly, those who heard voices instructing them to self-harm experienced multiple voices and it is possible that the presence of multiple voices increased the pressure felt by the individual to comply with instructions to self-harm. This requires further dedicated research.

Cases studies (Waugh, 1986; Kushner, 1967) and research evidence (Fenton et al, 1997) suggest that delusional beliefs may influence self-harming behaviours for some individuals diagnosed with schizophrenia and this was also found to be the case within the present study. However, a study conducted by Grunebaum et al (2001) reported no association between delusions and DSH this may be owing to the high prevalence of delusions (89%) within their schizophrenia subgroup and the fact that they did not explore antecedents to specific episodes of DSH. The delusional beliefs which influence self-harming behaviours within the current study were complex and were associated with ruminating upon the delusions for some. It has been suggested that the individuals' attributional style is an important factor which contributes to delusion formation (Garety et al, 2001) and it may be useful for treatment to target the attributional style of those whose delusional beliefs influenced their self-harming.

Pathways to Suicide Pacts

Participation within a dyadic suicide pact emerged as a wholly unexpected theme from the analysis process. In both cases, the suicide partner was a woman who the

participant had been romantically involved with. This is similar to other studies describing suicide pacts as typically involving a male and female partner (Brown et al. 1995). Participants who reported being involved in a suicide pact had previously engaged in DSH without their pact partner and this was also found to be the case in Brown et al's (1995) study. Both participants reporting this pathway indicated that their girlfriend had been the dominant partner who had first suggested the pact. This differs from previous research which suggests that an aggressive and depressed man, with a history of DSH typically convinces a female partner to participate in a pact (Rosenbaum, 1983; Rosen, 1981). It is possible that the men reporting participation within a suicide pact in the present study were aware that being seen as the dominant partner may have negative connotations and thus responded in a socially desirable manner to queries regarding who was the dominant partner within the pact.

The pathway to a suicide pact was aligned with the Relief Pathway and a joint dysfunctional ruminating process for one participant without the presence of positive symptoms of mental health problems, whereas for the other participant. This is in line with Hemphill and Thornely's (1969) study which suggests that mental illness is not a feature of dyadic suicide pacts and Brown et al's (1995) study which suggests that suicide pacts may function as a means of gaining relief for some. The present study also found that for another participant, DSH as part of a suicide pact was more in line with the Response to Mental Health Problems Pathway and in particular a joint delusional thinking process between the pact participants, often referred to as a folie a deux within the existing literature. A study of nine suicide pacts found that at least one member was mentally ill at the time of the pact (Brown et al, 1995) and that for some the suicide pact was in response to delusional beliefs. A case report by Salih (1981)

highlighted the role of a folie a deux as directly leading to DSH. The findings of the current study support the notion that mental disorders may influence participation within a suicide pact for some but not all individuals and that a folie a deux may increase the probability of engaging in a suicide pact.

Other Emergent Core Categories and Themes Related to Episodes of DSH

The present study identified a number of themes which were unrelated to a specific pathway to DSH episodes or were found across both pathways. These themes can be conceptualised as non-specific risk antecedents to episodes of DSH, which may predispose the individual towards DSH, but do not specifically lead to individual episodes of DSH. Therefore, interventions targeting these non-specific antecedents to episodes of DSH may be a useful preventative measure which would lead to a reduction in individuals developing self-harming behaviours in the first instance.

Similar to other studies exploring DSH in forensic populations, the present study found that participants had an index offence of a violent nature as opposed to a sexual nature. Du Rand et al (1995) and Kerkhof and Bernasco (1990) independently found that prisoners charged with violent offences such as murder or manslaughter were more likely to engage in DSH than controls. This may be owing to interpersonally violent offences, such as murder and manslaughter, stemming from interpersonal difficulties, an antecedent highlighted within this study as leading to episodes of self-harm, whereas sexual offences are more concerned with issues of power and control (Groth et al, 1977).

In line with previous research, the present findings suggest that individuals who self-harm had often employed multiple methods of DSH over the course of their life (Herpertz, 1995; Gratz, 2001; Favazza & Conterio, 1989). Also, the men within this study had employed lethal means of DSH during some episodes (Murase et al, 2003; Heila et al, 1997) and suicidal intent was found to be associated with episodes in which lethal means were employed to self-harm this has been found within other studies (Haw et al, 2003).

A family history of DSH was found within this study and it has been closely associated with suicidal behaviour, particularly for psychiatric patients irrespective of diagnosis within other studies. Roy (1983) found that amongst 5,845 consecutively admitted psychiatric patients 4.2% had a reported family history of suicide. Almost half of those with a family history of suicide had self-harmed (Roy, 1982, 1985a, 1985b). Twin and adoption studies suggest that familial risk factors for DSH are likely to be at least partly genetically transmitted (Baldessarini & Hennen, 2004). The findings of this study support the notion that having a family history of DSH increases the risk of DSH for individuals. The mediating link between a family history of DSH and self-harming behaviour may be observation / modelling. The present study found that some participants had observed self-harming behaviour in family members or their peers. However, it is important to note that none of the participants reported observation / modelling as directly influencing episodes of DSH. Modelling of DSH within forensic populations has been previously documented in inmates who had no prior history of self-harm engaging in these behaviours as a means of problem-solving after observing others self-harming (Allen, 1969; Rada & James, 1982). Similarly, a ‘contagious’ clustering quality to DSH has been described in young people who become aware of

peers who self-harm and has been reported as a strong risk factor DSH in a school-based study (Hawton et al, 2002; Gould et al, 1994; Rosen & Walsh, 1989).

Experience of adverse childhood events such as physical and sexual abuse and maternal abandonment was found within this study. Previous research has demonstrated a strong relationship between self-harm and the number and type of adverse life events experienced by individuals (Hawton et al., 2002; Meltzer, et al., 2002a). These adverse events include abuse and victimisation, particularly if it occurs during childhood (Gratz, 2003). Studies have found that childhood sexual and physical abuse predicted later DSH (Van der Kolk et al, 1991; Keeley et al, 2003; Romans et al, 1995) and childhood neglect is strongly associated with DSH (Boudewyn & Liem, 1995). Research focussed on forensic populations have also found a history of physical and sexual abuse was more common in those who self-harmed than in controls (Meltzer et al, 2003). Those who reported adverse childhood events within the present study did not highlight this as direct influence in relation to specific episodes of DSH. However, ruminating upon adverse childhood events was present for some of those experiencing the Relief Pathway. This may help to explain findings that not all studies have confirmed a link between DSH and childhood trauma and many people who have suffered sexual abuse do not go on to self-harm (Zweig-Frank et al, 1994; Brodsky et al, 1995). It is therefore possible that the mediating factor between adverse childhood events and DSH is ruminating upon these experiences.

The presence of mounting difficulties, such as interpersonal difficulties with family members, engaging in criminal activities, hanging out with the wrong company, the end of a romantic relationship, substance misuse and social isolation, was found to be

related to the lead up to episodes of DSH. It is possible that it is the accumulative effect of a number of difficulties significantly challenges the individual's poor repertoire of coping skills and thus the person turns to DSH as a means of gaining relief. This is similar in tone to the stress-vulnerability model proposed by Zubin and Spring (1977) in relation to schizophrenia, which suggests that individuals with a predisposition towards mental health problems become mentally ill when the stress they face becomes more than they can cope with and the same may be true for those who self-harm.

Interpersonal difficulties such as family conflicts and the ending of a romantic relationship were reported as antecedents to self-harming behaviours, irrespective of the pathway to episodes of DSH within this study. Researchers have suggested that precipitants to episodes of self-harm habitually involve situations of interpersonal conflict and loss (Keeley et al, 2003; Heikkinen et al, 1994; Rubenowitz et al 2001). It is possible that poor problem-solving skills result in some individuals struggling to resolve interpersonal problems and thus employing DSH as a means of coping as they cannot see any other way to change these problems. It has been suggested that interpersonal difficulties and poor problem solving skills may stem from experiences of adverse childhood events, such as physical abuse, sexual abuse and maternal abandonment which result in a lack of adequate parenting and inhibits learning healthy coping strategies to deal with emotional distress resulting from interpersonal problems (Linehan, 1993). Teaching individuals who engage in DSH strategies to become interpersonally effective may be a useful intervention to reduce the frequency of self-harming behaviours (Linehan, 1993).

Although, depression was not formally assessed within this study, feelings of depression and being 'down in the dumps' were reported as being associated with episodes of DSH. This supports findings of other studies in which elevated levels of depression have been frequently reported by those who self-harm (Harris and Barraclough, 1997; Mann et al, 1999; Herpertz, 1995; Stanley et al, 2001; Briere & Gil, 1998). However, it has been acknowledged by previous researchers that those who self-harm are not more likely to receive a diagnosis of major depression (Stanley et al, 2001; Soloff et al, 1994). It is possible that had participants within the present study been assessed following a DSH episode they may have received a formal diagnosis of depression. More than half of clinically depressed individuals have thoughts of DSH and this appears to be related to the severity of depression (Lonnqvist, 2000). Therefore, the findings of this study highlight the need for careful assessment of depression in those who engage in self-harm.

Social isolation was found to precede episodes of DSH and has been previously recognized as a risk factor for self-harm by a number of other researchers within the general population (Cooper et al, 2005; Kingsbury, 1994) and within forensic populations. Meltzer et al (2003) found that prisoners who engage in DSH often have a very small primary support group and severe lack of social support. Participants also described feeling as though they had been cast out into the world on their own with little family support. Depressive symptoms may play a contributory role in the social isolation experienced by participants within the present study. Depression may be a causal factor for those that withdraw from social contact of their own accord and may be a consequence for those who do not feel that they fit in with their peers or are

experiencing inter-personal conflicts. This is an area in need of further dedicated research.

Substance misuse was found to be an antecedent to episodes of DSH within this study and appears to be particularly prevalent among those who self-harm, with many researchers reporting a strong association (Zlotnick et al., 1999; Turell & Armsworth, 2000). Substance misuse in relation to DSH has been found to be an issue for men and those who have a criminal history (Hawton et al, 1997; Hawton et al, 1997b). Within the present study, drug use prior to episodes of DSH was more common than alcohol use. This supports previous research which suggesting a higher prevalence of drug use than alcohol use among those who self-harm (Hawton et al, 1997; Hawton et al, 1997b). Substance misuse may represent another maladaptive coping strategy employed by these individuals which provides a brief sense of relief from difficulties. The findings of this study suggests that the intoxicification experienced through substance misuse may provide a brief sense of relief for individuals who are experiencing mounting difficulties and have poor-problem-solving skills. However, substance misuse affects the individuals' thinking and may further impair problem-solving skills leading to the individual employing DSH as a means of problem-solving should substance misuse not provide the level of relief hoped for. This may help to explain findings that the risk of repetitive DSH is high within those that misuse substances (Hawton et al, 1997).

Researchers have conceptualised repetitive DSH as a strictly personal and private act which is typically concealed from others, perhaps owing to the complex grid of horizontal and vertical scars in various stages of healing (Sakinofsky, 2000). This was

also found within the present study. It is hypothesised that DSH is a private act for many men owing to societal attitudes towards their behaviour. Many participants reported that men who self-harm are seen by others as weak or 'crazy' and that others do not understand their motivation to self-harm. A sense of shame and stigma related to episodes of self-harm may continue even after individuals are admitted to psychiatric care, with researchers noting that once admitted to an institutional setting, individuals who engage in DSH often lose their identity and become equated with their self-harming behaviours and known to staff and patients alike as 'cutters', 'slashers' and 'head-bangers' (Podvoll, 1969; Burrow 1992). Their DSH is habitually perceived as 'performances' that are 'manipulative' and 'attention-seeking' (Burrow, 1992). Such negative attitudes towards those that self-harm within psychiatric care, is likely to be an impediment to potential therapeutic progress within inpatient settings and hinder those who self-harm from presenting to services.

Views of DSH-Related Interventions

The present study also explored mentally ill men's views of DSH-related interventions. Surprisingly, none of the men within this study had engaged in psychological treatment specifically related to their self-harming behaviours either within Rampton Hospital or outside of this setting. It is possible that these men have not been afforded the opportunity to explore their DSH as self-harm is even less acknowledged, accepted and understood in men than in their female counterparts (Taylor, 2003), this may be particularly true of mentally ill men within high secure hospital settings. It is of critical importance that men who self-harm are offered the opportunity to explore their behaviour as this is likely to reduce repetition and possibly prevent completed suicide. Despite not being offered psychological help, all participants reported that they would

have welcomed the opportunity to talk to someone about their self-harm. This mirrors Huband and Tantam's (2004) finding that women who self-wound ranked being encouraged to talk about and express their feelings about their past as the second most helpful strategy out of a possible 18 strategies for managing their DSH. The idea of taking part in group therapy was not considered to be a useful intervention within this study. This may be owing to DSH being a private act for individuals and the associated shame and stigma experienced may hinder taking part in a group intervention addressing DSH. It is therefore important that DSH is de-stigmatised and negative perceptions of those who self-harm addressed within medical and psychiatric services and within society as a whole (Mackay & Barrowclough, 2005; Burrow, 1992).

The lack of available means to engage in self-harm was cited as preventing episodes of DSH within Rampton Hospital. Ensuring that means to self-harm are unavailable appears to be a useful and logical preventative approach given that suicidal intent was often impulsive for those within this study and suicidal intent is not always present, but death may occur nonetheless if lethal means of DSH are employed. Being offered psychiatric medication was perceived to be an unhelpful professional intervention by participants within the present study. This finding contradicts Huband and Tantam's (2004) work in which taking prescribed medication was ranked as the fifth most helpful strategy out of a possible 18 strategies, by women who self-harm. Close nursing observations were experienced as intrusive and thus was perceived as unhelpful, although it was acknowledged that as a preventative measure these close observations hindered finding available means to engage in DSH.

Methodological Considerations

The present study adopted a qualitative Grounded Theory approach in which semi-structured interviews explored the pathways to DSH experienced by mentally ill men currently within a high secure hospital. This approach has a number of strengths and limitations which deserve careful consideration.

In terms of strengths of the study, the grounded theory approach adopted enabled the development of a theory which was grounded in the participants' experiences of episodes of DSH. The constant comparison method involved a continuing search for evidence to disconfirm the emerging theory, thereby enhancing the trustworthiness of the derived theory. The qualitative approach enabled the complexity of factors related to episodes of DSH to be captured and unexpected themes to be identified. The study design highlighted areas of current good practice within the MHSD, such as limiting the availability of means to self-harm, and areas in need of improvement such as offering the men the opportunity to engage in treatment addressing their DSH.

The study was limited by its small sample size of seven participants. Although Jackson (2000) found that 19% of patients within the MHSD at Rampton Hospital had engaged in self-harming behaviour within this setting, very few patients indicated a willingness to take part in this study. It is possible that issues related to shame and stigma associated with episodes of DSH inhibited these patients from taking part in the study. This may indicate that participants within the study were different from other patients who have self-harmed and are currently admitted to the MHSD. Participants within the sample had not engaged self-harming behaviours for at least 2 years; therefore, we do not know how far these findings can be generalised to those with ongoing episodes of

DSH. As with much qualitative research the sample was naturalistic and non-random, consisting of mentally ill men detained under the conditions of a high-secure hospital and this again raises questions regarding the generalisability of the findings to other groups, such as men who self-harm within the general population. However, several characteristics of the sample within this study were similar to those found in other studies exploring DSH, including impulsivity (Williams, 1997), a family history of DSH (Roy, 1983), experience of adverse childhood events (Van der Kolk, 1991; Boudewyn & Liem, 1995), depression (Mann et al, 1999; Herpertz, 1995; Stanley et al, 2001; Briere & Gil, 1998) and substance misuse (Zlotnick et al, 1999; Turell & Armsworth, 2000; Hawton et al, 1997; Hawton et al, 1997b).

The study relied heavily upon participants' verbal reports of mental activity, but did not seek evidence as to what actually occurred. Such studies have often been criticised as participants may have difficulty in verbalizing their motivations and so offer inaccurate explanations. Some may even go so far as to fabricate explanations if they are embarrassed by their true reasons. (Nisbett & Wilson, 1977). People often view themselves in an unrealistic manner and, at best, there is only a modest correlation between the ways in which people describe themselves and the way in which they are perceived by others (John & Robbins, 1993; Klonsky et al, 2002). In response to such criticism, it could be argued that the self-report approach adopted within this study has the advantage of reducing demand characteristics, as participants are not overtly asked to provide reasons for, or justify a behaviour, which is often seen as socially undesirable. Participants maybe less likely to withhold, alter or fabricate information and thus variables which may prompt or reinforce DSH can emerge without researcher presumptions biasing the research from the outset.

Similar to other qualitative studies, it is possible that the present study may be open to subjective biases in interpretation and coding of the data as it was not possible to enlist an independent coder and establish inter-rater reliability. However, credibility checks were made by frequently reflecting back the researchers' understanding of participant comments during the interview and participants reviewed the complete transcript of their interview and indicated their satisfaction with the accuracy of the transcribed data. Following the coding and analysis stage of this research, the results were presented to all participants in order to establish whether they felt that the findings reflected their experience of first and typical episodes of DSH and also their views of DSH-related interventions. Direct quotations from the interviews were included in the results and an audit trail was created to enable other researchers to judge the validity of the derived themes, core categories and theory for themselves. Another limitation of this study is that it has a fairly simplistic understanding of the function of language. Language is a communicative tool and it is possible that participants were trying to persuade the researcher rather than simply "telling it, as it is".

It is important to note that as participants were recruited within a closed institution, it is possible that they discussed the interview process and questions amongst themselves and this may have influenced the findings. It is unclear as to whether this occurred or not as the recruited participants were not directly asked, however, one participant admitted that he had volunteered to take part after asking a fellow participant what the researcher was like.

Clinical Implications and Directions for Future Research

The present study describes a theoretical framework, grounded in research data, which is likely to prove useful for clinicians working with mentally ill men within high secure hospitals who have a history of DSH. The theoretical framework identifies a number of core categories, which can be conceptualised as components along a causal pathway to episodes of DSH for this population; the core components can serve to guide assessment of self-harming behaviours within this population, aid formulation of DSH and identify targets for treatment and change for self-harming behaviours within mentally men.

Previous studies exploring motivations and functions for self-harming behaviours have tended to employ a checklist method, in which individuals endorse items relevant to their experience (NICE, 2004; Klonsky, 2007). Functions of DSH identified within the literature may appear to be distinct owing to the methodology employed. By exploring pathways to episodes of self-harm, the present study found that functions of DSH which had previously been conceived of as distinct and independent followed a similar causal route within the Relief Pathway and are inter-related. Therefore, future research needs to explore causal pathways experienced by those that self-harm in greater detail. The findings also indicate that clinicians treating individuals who engage in self-harming behaviours need to carefully assess each individual episodes of DSH as pathways to DSH may differ within individuals across episodes and DSH may serve multiple functions within a single DSH episode.

This study identified two major pathways to DSH within mentally ill men in a high secure hospital. Further research is required to substantiate this within mentally ill men

in other settings and within other populations. Differing pathways to episodes of DSH indicates different treatment needs, for example those who experience the Response to Mental Health Problems Pathway may benefit from interventions which directly address positive symptoms of schizophrenia, whereas those who experience the Relief Pathway may benefit from treatment which addresses their cognitive style and enhances problem-solving ability.

Some individuals who experienced the Relief Pathway described DSH as having an addictive quality. It may be useful for clinicians to employ intervention strategies derived from the addiction field such as cue exposure, in the treatment of those who experience DSH as an addiction. Similarities between DSH and addiction requires further exploration.

There is little known about the mediating factors which lead individuals to engage in DSH in response to positive symptoms of schizophrenia. The present study suggests that beliefs concerning the power of auditory hallucinations may play a contributory role. Therefore, dedicated research exploring how beliefs regarding the power of voices influence individuals to engage in self-harming behaviours. Within this study those who heard multiple voices complied with the voices instructions to harm themselves and it is possible that the presence of multiple voices increases the likelihood of compliance with auditory command hallucinations. Research is required to explore this hypothesis. The present findings also suggest that for mentally ill men cognitive factors such as rumination played a more critical role in the lead up to an episode of self-harm than negative affective states which has been found for women, thus suggesting that

cognitive processes are more pertinent in male DSH than in their female counterparts. This is clearly an area in need of further dedicated research.

The research design allowed for first and typical episodes of DSH to be explored separately and compared and contrasted in order to develop an understanding of potential changes in patterns of DSH. The findings suggest an evolution in self-harming behaviours. Whereas first episodes were often concerned with calling attention to distress typical episodes were private and attention was unwanted. The frequency and intensity of episodes of DSH increased overtime. This suggests that clinicians need to intervene with mentally ill men who self-harm as early as possible as this group often employed lethal means to self-harm which may result in death. This adds some urgency to developing interventions specific to this group.

Conclusion

There is a dearth of research evidence exploring DSH within men and even less concerned specifically with mentally ill men in secure hospitals. This is of some concern as mentally ill men may currently be engaging in treatment designed with the needs of women diagnosed with borderline personality disorder as much of the literature has focussed on this population (Shaw, 2002). The present study aimed to explore the causal pathways to episodes of DSH as experienced by mentally ill men currently detained within a high-sure hospital and their views of related interventions in an effort to develop a conceptual understanding of DSH within this population. Seven men with a history of repetitive DSH participated in audiotaped semi-structured interviews in which they recalled antecedents and functions of typical episodes. Transcribed interviews were analysed and coded using grounded theory methods.

Results of this study indicate a two-pathway aetiology of episodes of DSH within this population, which were termed the Relief Pathway and the response to Mental Health Problems Pathway. Differentiation between pathways was related to the presence or absence of positive symptoms of schizophrenia. Participation within a dyadic suicide pact emerged as a wholly unexpected theme. A number of factors were found to be present across pathways or were not reported in relation to specific episodes and thus were conceptualised as predisposing factors which may influence self-harm. Surprisingly, none of the participants had been offered the opportunity to engage in psychological therapies addressing their DSH, despite wishing they had someone to talk to about their behaviour. Psychiatric medication and close nursing observations were felt to be unhelpful professional interventions that participants had experienced. Further dedicated research is required to substantiate the two-pathway model of DSH proposed within this thesis within other male populations.

APPENDIX P

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